MISSISSIPPI LAW JOURNAL

SEVENTY-FIFTH ANNIVERSARY

MEMORIAL AND DEDICATION TO PROFESSOR TOM MASON
David W. Case
William M. Dalehite, Jr.
Robert C. Khayat
Robert A. Weems

ARTICLE
CHECKING UP ON THE MEDICAL MALPRACTICE LIABILITY INSURANCE 'CRISIS' IN MISSISSIPPI: ARE ADDITIONAL TORT REFORMS THE CURE?
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FINAL REPORT OF THE SUPREME COURT OF MISSISSIPPI TASK FORCE ON GENDER FAIRNESS
Introductory Comments by John W. Wirthlin III

VOLUME 73 SPRING 2004 NUMBER 4

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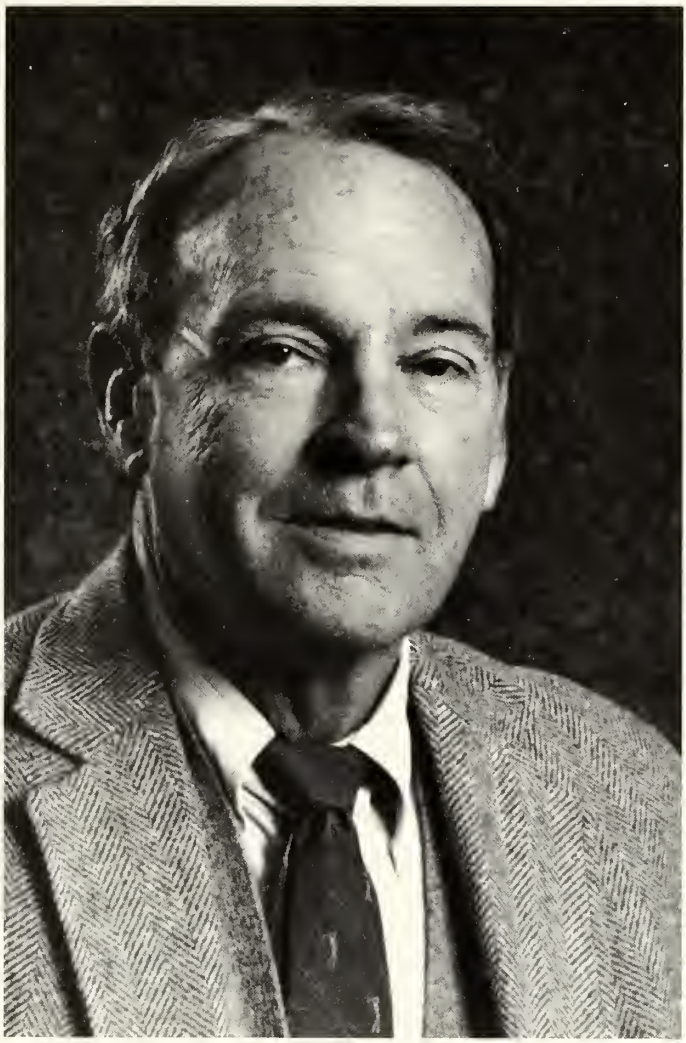
In Memoriam

This volume of the *Mississippi Law Journal* is proudly dedicated to the memory of Professor Tom Mason, a longtime professor, mentor and friend to many students, faculty and staff who have been a part of the University of Mississippi School of Law during the last three decades. There are countless current and former students and colleagues who are grateful to have learned from such a wise man and who are all better for having known him. Among his many contributions to legal scholarship and the Mississippi legal community were his numerous practical and insightful articles published in the *Mississippi Law Journal*. The following memorial passages are a testament to his profound influence and presence at the law school as well as his integrity and kindheartedness as a person. It is with deep sadness that we mourn his passing but with great fondness that we remember his contributions and his spirit.

Corey D. Hinshaw
2003-2004 Editor-in-Chief



IN MEMORIAM
THOMAS R. MASON
1934-2004

REMEMBERING TOM MASON

David W. Case[*]

I am honored to write this remembrance on behalf of Professor Tom Mason's former students at the University of Mississippi School of Law. A few short years ago, I was privileged to join Tom in honoring his retiring colleague and good friend, Professor Michael Featherstone, with respective tributes in the *Mississippi Law Journal*.[1] Regretfully, Tom's untimely death precludes the same chance to celebrate a life well-lived and career well-performed at the best possible time—when the honoree is able to enjoy such memories with us. Thus, these words, belated as they are, are tinged with a heightened sense of sadness and loss. In any event, it is extremely fitting that the *Mississippi Law Journal* dedicate this volume to Tom Mason, a favorite teacher, colleague and friend who gave more than thirty years of dedicated service to our Law School.

When I took my first class—Oil & Gas Law—from him in 1986, Tom was in his fourteenth year at the Law School. He already had been voted by students as the Law School's outstanding professor on two occasions. He was my professor in three more classes—Evidence, Federal Trial Practice, and Pretrial Litigation—before I graduated. Tom's classroom style was much appreciated by his students—relaxed, never over-

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[*] Assistant Professor of Law, University of Memphis Cecil C. Humphreys School of Law. Professor Case received his J.D. from the University of Mississippi School of Law in 1988.

[1] *See* David W. Case, *Tribute to "Iron Mike" Featherstone*, 70 MISS. L.J. 497 (2000); Tom R. Mason, *About Mike Featherstone*, 70 MISS. L.J. 501 (2000).

bearing and full of good humor and dry wit. Importantly, Tom had been a practicing attorney for a decade before joining the Ole Miss faculty in 1973. To our immense satisfaction, his teaching approach recognized that the vast majority of us also would be practicing attorneys upon graduation. Thus, his lectures and classroom instruction typically focused upon conveying the practical knowledge and honing the skills essential for the practice of law. For these reasons, Tom's courses were always among the most popular offerings at the Law School.

Tom's work over the last several years reflects that his commitment to his students and their futures as practicing attorneys remained unwavering. In addition to his outstanding work in the classroom, Tom was the heart and soul of the law school's student internship, trial advocacy and moot court programs. Furthermore, similar to his teaching, his research and writing continued to focus on conveying knowledge of importance and use to practicing attorneys and trial judges in Mississippi.[2]

Tom's esteem among the law student body was not based solely upon the popularity of his course offerings. Tom stood out on the faculty for being extremely accessible to the students. It was obvious to us that he cared about our lives and our future careers. Personal troubles could be taken to him and the advice and reassurance we received reflected his genuine interest and concern. Tom clearly enjoyed interacting with law students, both inside and outside the classroom, and his approachability was a natural expression of that fact. The recent vote by the student body to bestow upon Tom his third outstanding professor award reflects that his excellent relationships with the students have remained a constant over the years.

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[2] *See* Tom R. Mason, *The Little Rule that Never Was: Mississippi Rule of Evidence 301--Presumptions in Civil Actions and Proceedings*, 70 MISS. L.J. 743 (2000); Tom R. Mason, *Navigating the Maze of Evidence of Character and Other Crimes, Wrongs or Acts: Mississippi Rules of Evidence 404 & 405 in Criminal Cases*, 71 MISS. L.J. 835 (2002).

During my last year of law school, I had the unique opportunity to spend more quality time with Tom Mason than is the norm in the law professor-student relationship. He was my landlord. When I married my classmate and Professor Featherstone's daughter Catherine between our respective second and third years of law school, Tom offered to rent us the small "mother-in-law cottage" immediately behind his house out in Pea Ridge Farm in Oxford. Given the bargain basement monthly rent figure he quoted, we said yes immediately despite some vague misgivings about living so proximate to one of our professors.

As it happened, Tom was by far the best landlord we ever had. He would bend over backwards to see that needed repairs were made within a twenty-four-hour period. He insisted that we have the complete run of his property, including the use of his boats on the large pond behind the house. If not for his consistent habit of knocking on our door before seven o'clock on Saturday mornings to enlist my help with some ongoing chore or project, he would have been the perfect landlord. At such times, I would be compelled to remember that he in fact was not just my landlord, but my law professor who would soon be writing the Evidence or Pretrial Litigation final exam I would be taking at the end of the semester. I would also recall the ridiculously low rent he was charging us. This would motivate me to roll out of bed, open the door and pretend that moving heavy objects around in his garage at the crack of dawn on a Saturday morning would have been my idea had I only thought of it first.

When I sheepishly told him at the end of my last semester that I was broke and not presently able to pay the last month's rent, Tom told me to forget it and called it a graduation present. I was, and remain, touched and humbled that he would be so considerate, but I was by no means surprised. Tom's kindness in this regard was reflective of his unflagging concern for his students, and his attempt to spare my feelings by calling the gesture a "graduation present" was typical of his good heart. It is this aspect of Tom Mason that I believe his former students will miss the most. As large a debt as his

former students owe him for his contributions to our development as future lawyers, we owe Tom a much larger debt of gratitude for being there for us whenever we needed him. Our lives were made all the better for their intersection with his.

REMEMBERING TOM MASON

William M. Dalehite, Jr.[*]

I first met Tom Mason in 1981 when our law firm was contacted about supporting a trial competition at the Law School. This original idea from Tom later became the Steen Reynolds & Dalehite Trial Competition at the Law School, which we have been proud to support for over twenty years.

I knew that Tom had been a defense attorney in Oklahoma, and I also knew that he was very highly regarded by his students. Anytime our law firm interviewed potential candidates for positions in our firm, my first question was to ask was whether or not they had taken any courses under Tom Mason. His opinion of a student was essential in our hiring process.

Tom had a very practical approach to his teachings and his involvement with the trial competition. It is obvious that he was always held in high esteem by his peers and by his students, and he was equally regarded by the Bar of the State of Mississippi.

I also observed him as a reporter to the Supreme Court of Mississippi Advisory Committee on Rules of Procedure. He provided careful analysis and insight into current evidentiary questions and his annotations that were presented to the Committee were timely and always very useful.

I also knew Tom Mason, the person, as someone who cared about others, he cared about his students and he cared

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[*] Member, Steen, Dalehite & Pace, LLP, Jackson, Mississippi.

about his friends. He did not take himself too seriously, and only occasionally resemble the typical law professor. He was a person, once you got to know him, of great warmth and compassion and it was obvious he cared deeply about his role as a teacher and his personal contact with his students.

He was truly an extraordinarily competent individual and the Bar of this State and the lives of the students that he has touched are far better off as a result of his efforts.

REMEMBERING TOM MASON

Robert C. Khayat[*]

Tom and Darlene Mason came into our lives on a beautiful June morning in 1973. Guff Abbott and I met their plane at the Memphis airport and drove Tom and Darlene to Oxford for interviews that ultimately led Tom to becoming a member of the Law School faculty. Although we did not know it at the time, an extraordinary couple became members of our community, and a gifted man became a pillar of strength at the Law School.

Students, staff, and faculty were challenged, inspired, encouraged, supported and loved by Tom Mason during his thirty-one years as a member of the law faculty. In his quiet, but strong way, he provided stability and flexibility, strength and compassion, objectivity and sensitivity to the issues we confronted. In many ways, Tom was the conscience of the Law School.

Students who were privileged to sit in his torts, evidence, oil & gas or trial practice courses enjoyed the benefits of a highly intelligent, down-to-earth professor.

The years of law practice in Muskogee enabled him to present theoretical and policy-oriented material in a practical manner. Through all of his work, compassion was evident.

The lives of all of us who interacted with Tom as colleagues, students or friends were enriched by his selfless investment of himself in others. About Tom it can truly be said

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[*] Chancellor, University of Mississippi. Prior to being selected as Chancellor, Chancellor Khayat served as a Professor of Law at the University of Mississippi School of Law.

that his was a life well lived. Thomas Ray Mason will be missed but not forgotten.

REMEMBERING TOM MASON

Robert A. Weems[*]

Tom Mason and I taught together at this law school for twenty-six years. We both taught Torts and Evidence. We often talked about these subjects and many other things as well. We both liked to listen to audio tapes in the car, and we often swapped tapes. He was a good friend, a very good friend.

He was a very valuable member of this faculty. He taught his courses well, being selected Teacher of the Year three times. He served as Associate Dean for nine years. He organized and ran our Externship program, where students in their last semester went out and worked for district attorneys and other public officials. He organized and operated our ABOTA Trial Practice course, where outstanding trial attorneys from all over the state came to the University to teach our students how to prepare for and try lawsuits. He coached Moot Court teams too numerous to count. He was the Reporter for the Mississippi Supreme Court Advisory Committee on the Rules of Evidence. He published several articles in the *Mississippi Law Journal*. He did all of this as he did everything else, quietly and competently. It will take more than one person to replace him.

He was a good and kind man. His students knew it and loved him for it. He almost never said anything uncomplimentary about anyone, and on the few occasions that he felt an obligation to do so it was in the gentlest terms possible. Although he was a proud graduate of and athlete of the University of Oklahoma, I could not get him to say anything unkind

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[*] Professor of Law, University of Mississippi School of Law.

even about Nebraska. He was always for the person in trouble, the professor who might not get tenure, the student who had been academically dismissed and was petitioning for readmission, the employee that some thought did not measure up. When it came to taking the side of the person as opposed to sticking to the letter of the rule, he took the part of the person every time.

And he was a man, a Westerner, an Oklahoman. He knew who he was, and he knew what he was. He marched to the beat of his own drummer. He did not try to impress anyone. He did what he thought he ought to do and what he wanted to do and not what others might have thought he ought to do. When informed that smoking was no longer permitted in the law school, he closed the door of his office and smoked anyway. When he was dying, and he knew he was dying, he somehow dragged himself out of bed and came to school to teach his classes until the time came, two weeks before he died, that he could not stand. John Wayne, another Westerner, said "Courage is when you are scared to death but you saddle-up anyway." I don't know if Tom was scared or not, but he sure saddled-up. I will always have a soft spot in my heart for Oklahoma for producing Tom Mason.

CHECKING UP ON THE MEDICAL MALPRACTICE LIABILITY INSURANCE CRISIS IN MISSISSIPPI: ARE ADDITIONAL TORT REFORMS THE CURE?

E. Farish Percy[*]

INTRODUCTION

Mississippi's medical malpractice liability insurance crisis has ignited considerable debate over the cause of the crisis and the best manner in which to remedy it. Nationally, the market for medical malpractice liability insurance began to harden in late 1999 and 2000 as rates for medical malpractice insurance began rising.[1] In late 2001, St. Paul, the second largest national medical malpractice carrier which insured hundreds of physicians in Mississippi, announced that it was exiting the business nationwide.[2] In 2002, malpractice insurers substantially raised premiums for malpractice insurance in Mississippi and in many other areas of the country.[3] During Mississippi's 2002 regular legislative session, physicians began actively campaigning for tort reform, rallying at the state capitol and taking out full page newspaper advertisements describing Mississippi as "lawsuit central" where only "jackpot justice" prevails.[4] Despite these efforts, no tort reform measures were passed during the regular session.

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[*] Assistant Professor of Law, University of Mississippi School of Law.

[1] U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REQUESTERS: MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 9 (June 2003) [hereinafter MULTIPLE FACTORS].

[2] Pamela Berry, *Doctors Turning to Last Resort*, CLARION-LEDGER (Jackson, Miss.), July 21, 2002, at A1.

[3] For a detailed discussion of the recent rate increases in Mississippi and elsewhere, see *infra* notes 269-303 and accompanying text.

[4] Jerry Mitchell, *Doctors Taking Fight Over Suits to Capitol*, CLARION-LEDGER (Jackson, Miss.), Jan. 16, 2002, at A1; Advertisement, CLARION-LEDGER (Jackson, Miss.), Jan. 15, 2002, at A3 (stating, in a full page advertisement paid for by Mississippi physicians, that "Lawsuit Epidemic Threatens Health Care; Only the Mississippi Legislature Has the Cure").

On June 17, 2002, the American Medical Association designated twelve states, including Mississippi, as states in crisis and thirty others as states experiencing serious problems.[5] In late August 2002, Governor Ronnie Musgrove called a special session to address medical malpractice liability in Mississippi as well as the state's general civil justice system.[6]

During the 2002 special session, two pieces of tort reform legislation were passed. The first, House Bill 2, focuses solely on medical malpractice litigation and contains a $500,000 cap on noneconomic damages in medical malpractice cases, a provision substantially limiting joint and several liability and a requirement that plaintiffs' attorneys certify that they have consulted with an appropriate expert.[7] The second, House Bill 19, contains reforms applicable to all tort claims, including caps on punitive damages, a prohibition on recovery for damages for loss of enjoyment of life resulting from death and a repeal of the fifteen percent penalty that was previously assessed to defendants who lost on appeal.[8]

In early 2003, despite passage of these tort reform measures, there were few admitted medical malpractice insurers writing new policies in Mississippi.[9] A survey conducted by

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[5] The twelve states were Florida, Georgia, Mississippi, New Jersey, Nevada, New York, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia. In early 2003, the AMA designated Arkansas, Connecticut, Illinois, Kentucky, Missouri and North Carolina as additional states in crisis. Bruce Japsen, *AMA Says Illinois, 5 Other States Join Malpractice Crisis*, CHI. TRIB., Mar. 4, 2003, at 2. Currently, the AMA indicates that nineteen states are in crisis, that twenty-five others are in serious trouble and that in some of the remaining six states, California, Colorado, Indiana, Louisiana, New Mexico and Wisconsin, problems are beginning to surface. Am. Med. Ass'n, *Medical Liability Reform – NOW!* 5 (Mar. 26, 2004), *at* http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlr2004.pdf.

[6] Julie Goodman, *Gov. Calls Special Session with a Twist*, CLARION-LEDGER (Jackson, Miss.), Aug. 24, 2002, at A1.

[7] Act of Oct. 8, 2002, ch. 2, 2003 Miss. Laws 1274 (codified in various Sections of Mississippi Code). For a more detailed discussion of House Bill 2, see *infra* notes 125-42 and accompanying text.

[8] Act of Dec. 3, 2002, ch. 4, 2003 Miss. Laws 1289 (codified in various Sections of Mississippi Code Chapter 11) (the statute is incorrectly entitled Senate Bill 19 in the General Laws). For a more detailed discussion of House Bill 19, see *infra* notes 143-55 and accompanying text.

[9] MISS. DEP'T OF INS., REPORT ON AFFORDABILITY AND AVAILABILITY OF MEDICAL MALPRACTICE INSURANCE IN THE STATE OF MISSISSIPPI (Jan. 3, 2003), *avail-*

the Mississippi Department of Insurance indicated that ten doctors had left or were planning to leave the state while several more were considering leaving or retiring.[10] To make matters worse, Reciprocal of America, a Virginia based company which insured 535 doctors and 46 hospitals in Mississippi, was placed in receivership in February of 2003, forcing some physicians to temporarily stop practicing while they searched for coverage.[11] In response, the Mississippi Legislature enacted the Medical Malpractice Insurance Availability Act (MMIAA), which authorized the Mississippi Tort Claims Board to sell malpractice insurance to all licensed health care providers in Mississippi.[12] Even though the MMIAA clearly resolved any availability crisis, tort reform continued to be a prominent and controversial issue, as evidenced by the 2003 Mississippi gubernatorial and legislative campaigns, during which many candidates called for additional tort reform measures governing medical malpractice cases.[13]

Prior to and during the 2004 regular legislative session, Governor Haley Barbour and other tort reform advocates supported lowering the cap on noneconomic damages in medical malpractice cases from $500,000 to $250,000 and requiring all medical malpractice cases to be screened by a medical review panel.[14] In addition to these reforms, the Mississippi State Medical Association sought to establish a voluntary patient

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able at http://www.doi.state.ms.us/medmalavailabilityreport.pdf (last visited April 10, 2004) [hereinafter MDI REPORT].

[10] *Id.*

[11] Pamela Berry, *ER Closes After Insurance Lost*, CLARION-LEDGER (Jackson, Miss.), Feb. 25, 2003, at B1; Julie Goodman, *Bill Calls for Hospital Risk Pool*, CLARION-LEDGER (Jackson, Miss.), Feb. 12, 2003, at B2.

[12] Act of Apr. 24, 2003, ch. 560, 2003 Miss. Laws 961 (codified at MISS. CODE ANN. § 83-48-5 (Supp. 2003)). For a more detailed discussion of the MMIAA, see *infra* notes 156-61 and accompanying text.

[13] *See, e.g.*, Julie Goodman, *Battle Looms Between State Leaders, Legislature Over Tort Reform*, CLARION-LEDGER (Jackson, Miss.), Nov. 16, 2003, at A1; Sid Salter, *Campaign Donor Lists Reflect Continuation of Tort Reform Battle*, CLARION-LEDGER (Jackson, Miss.), Sept. 21, 2003, at G1; Sid Salter, *Barbour, Musgrove Are Raising Historic Campaign Cash Totals*, CLARION-LEDGER (Jackson, Miss.), Aug. 31, 2003, at G1.

[14] Lynne Jeter, *"Haley's Plan" to Address Mississippi's Major Healthcare Issues*, MISS BUS. J., Jan. 12, 2004, at B3.

compensation fund which would cap participating health care providers' liability for all damages excluding future medical costs at $500,000.[15]

Legislative bills were introduced during the 2004 regular session which contained these and other tort reform measures. Senate Bill 2870, which died in the Senate, would have established a patient compensation fund and capped a patient's total recovery for noneconomic and economic damages, exclusive of future medical expenses, at $500,000.[16] Senate Bill 2763, which was passed by the Mississippi Senate, contained provisions which would have, among other things, limited noneconomic damages in all cases to $250,000 and established a mandatory medical review panel to screen all malpractice cases and render a nonbinding decision as to whether the defendant breached the standard of care, which decision could later be admitted into evidence at trial.[17] Although an amended version of the bill was passed by the House Judiciary A Committee, the bill died in the House.[18] The Senate and

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[15] Lynne Jeter, *Medical Liability Insurance Reform Tops MSMA's Agenda*, MISS. BUS. J., Jan. 12, 2004, at B3.

[16] S. 2870, 2004 Leg., Reg. Sess. (Miss. 2004). Under the proposed legislation, a health care provider would be required to qualify for participation in the fund by obtaining malpractice insurance with $100,000 of coverage for each claim or by filing proof of financial responsibility. The provider would also be required to pay the surcharge assessed by the fund. A qualified provider's liability would be capped at $100,000. A plaintiff's total recovery for economic and noneconomic damages, exclusive of future medical services, would be capped at $500,000. The fund would be responsible for paying that portion of the judgment or settlement exceeding $100,000. *Id.* § 2. In addition, all claims against qualified providers would be reviewed by a medical review panel consisting of three physicians and one nonvoting attorney. The panel would render a nonbinding opinion as to whether the provider deviated from the standard of care and whether such deviation caused the plaintiff any damages. *Id.* § 6(1)-(8). The proposed legislation appears to have been modeled after the legislation which established Louisiana's Patient Compensation Fund. For an overview of Louisiana's Patient Compensation Fund, see LA. REV. STAT. ANN. § 40:1299.44 (establishing the fund); LAW. REV. STAT. ANN. § 40:1299.42 (capping all damages excluding future medical expenses at $500,000, making qualifying providers responsible only for the first $100,000 of any payment, and making the fund responsible for any amount exceeding $100,000); LA. REV. STAT. ANN. § 40:1299.47 (requiring medical malpractice cases to be screened by a medical review panel).

[17] S. 2763, 2004 Leg., Reg. Sess. (Miss. 2004).

[18] *Id.* (as amended by the House Judiciary A Committee).

House were unable to agree whether additional caps on noneconomic damages were necessary.[19] By the end of the 2004 regular session, no significant tort reform legislation had passed.

Governor Haley Barbour called a special legislative session to address tort reform and continues to advocate a $250,000 cap on noneconomic damages.[20] Given that legislators were unable to agree on tort reform during the regular session, it is uncertain whether any legislation will be passed during the special session. Even if some tort reform legislation is passed during the special session, tort reform will likely continue to be a controversial issue.[21]

Despite the occurrence of similar medical malpractice liability insurance crises in the past, one during the mid-1970s and another during the mid-1980s, there continues to be widespread disagreement over the causes of the past and current crises as well as the manner in which to alleviate the current crisis and prevent future ones.[22] Three predominant theories

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[19] Julie Goodman, *Barbour Calls Lawmakers Back to Work*, CLARION-LEDGER (Jackson, Miss.), May 14, 2004, at A1.

[20] *Id*; Lynne Jeter, *Physicians Back Governor's Push for More Tort Reform*, MISS. BUS. J., May 10, 2004, at B7. Governor Barbour also designated voter identification as an agenda item for the special session. Goodman, *supra* note 19.

[21] This article was written in the spring of 2004 prior to the Mississippi Legislature's passage of House Bill 13 in June of 2004. This article, however, went to print after passage of House Bill 13, which implemented numerous tort reform measures, many of which are applicable to medical malpractice cases. Act of June 16, 2004, ch. 1, 2004 Miss. Laws __ *available at* http://billstatus.ls.state.ms.us/documents/20041E/pdf/HB/0001-0099/HB0013SG.pdf. Although House Bill 13 did not lower the cap on noneconomic damages to $250,000 or mandate a medical review panel, it did enact other tort reforms applicable to medical malpractice cases. As is further discussed in Appendix D, which reviews and comments on the provisions of House Bill 13 applicable to medical malpractice cases, the enactment of these additional tort reform measures is not sufficiently supported by the evidence reviewed in this Article.

[22] Although the crisis in the mid-1970s was most severe in the medical malpractice liability line of insurance, the crisis in the mid-1980s was widespread, affecting many lines of liability insurance, including medical malpractice, products liability, directors' and officers' liability, motor carrier liability, general liability and liquor liability. U.S. DEP'T OF JUSTICE, REPORT OF THE TORT POLICY WORKING GROUP ON THE CAUSES, EXTENT AND POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY 6-14 (1986) [hereinafter DOJ REPORT]. As in the mid-1970s, the current crisis appears to be most severe

emerged as explanations for the widespread liability insurance crisis of the mid-1980s. The competing explanations are: (i) that tort liability greatly expanded during the decade preceding the crisis, caused not only by a dramatic increase in the number of tort claims and the amount of jury awards, but also by doctrinal shifts in tort law which made it difficult for insurers to accurately predict future losses; (ii) that the crisis resulted from the natural insurance underwriting cycle, characterized by "soft" markets during which interest rates are relatively high, thereby giving insurers an incentive to engage in price competition in order to maintain market share and obtain premium dollars to invest, followed by "hard" markets during which interest rates are relatively low, thereby giving insurers an incentive not only to increase premium rates, but also to tighten their underwriting criteria and (iii) that the insurance industry's exemption from most federal antitrust regulation pursuant to the McCarran-Ferguson Act enabled insurers to collude and set artificially high prices in order to reap "super" profits.[23] These same theories are currently being advanced by many as competing explanations for the present medical malpractice insurance crisis.[24]

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in the medical malpractice line.

[23] For a discussion of the three predominant theories as well as other theories concerning the causes of the 1985-1986 crisis, see generally Kenneth S. Abraham, *Making Sense of the Liability Insurance Crisis*, 48 OHIO ST. L.J. 399 (1987); Jay Angoff, *Insurance Against Competition: How the McCarran-Ferguson Act Raises Prices and Profits in the Property-Casualty Industry*, 5 YALE J. ON REG. 397 (1988); Kyle D. Logue, *Toward a Tax-Based Explanation of the Liability Insurance Crisis*, 82 VA. L. REV. 895 (1996); George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521 (1987); Ralph A. Winter, *The Liability Crisis and the Dynamics of Competitive Insurance Markets*, 5 YALE J. ON REG. 455 (1988).

[24] *See, e.g.*, Jimmie E. Gates, *Fighting Lawyers, Fleeing Doctors: Seeking A Cure*, CLARION-LEDGER (Jackson, Miss.), Aug. 11, 2002, at A1 (noting that doctors blame the state's legal climate while lawyers blame insurers' bad investments); Rachel Zimmerman & Christopher Oster, *Assigning Liability: Insurers' Missteps Helped Provoke Malpractice "Crisis,"* WALL ST. J., June 24, 2002, at A1 (explaining cyclical nature of insurance cycle and impact of insurers' business practices). As evidence that some people currently point to the insurance industry's exemption from most antitrust regulation as a contributing cause of increased premiums nationally, see S. 352, 108th Cong. (2003), entitled The Medical Malpractice Insurance Antitrust Act of 2003, introduced by Senator Patrick Leahy to ensure that

Efforts to accurately diagnose the crisis have been hampered by the politicization of the tort reform issue by special interest groups. As other commentators have suggested, physicians and medical insurers have focused public attention on the state's civil justice system as the primary cause of the current crisis.[25] Many of the claims made concerning Mississippi's civil justice system were exaggerated. For example, contrary to claims that there had been a mass exodus of physicians from the state, only a handful of physicians actually left the state due to perceptions about the civil justice system.[26] In fact, the number of physicians in Mississippi increased slightly from 1997 to 2002.[27] In a 2003 study, the General Accounting Office (GAO) found that, although physicians did respond to malpractice pressures in a manner which reduced access to emergency surgery and obstetric services in a few areas in Mississippi, such access problems were not widespread and "were limited to scattered, often rural, locations," many of which had longstanding problems recruiting physicians.[28] The GAO further found that "many of the reported physician actions and hospital-based service reductions were not substantiated or did not widely affect access to health care."[29] In October of 2003, Modern Physician magazine ranked the top seventy-five places in the nation to practice medicine and included Hattiesburg as the twenty-seventh

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insurers do not engage in price fixing or other collusive behavior.

[25] Neil Vidmar & Leigh Anne Brown, *Tort Reform and the Medical Liability Insurance Crisis in Mississippi: Diagnosing the Disease and Prescribing a Remedy*, 22 MISS. C. L. REV. 9, 10-12 (2002) (noting that theories concerning the cyclical nature of the insurance industry as well as the industry's business practices have largely been ignored in the public debate).

[26] *See* MDI REPORT, *supra* note 9 (finding that only ten physicians had left or were planning to leave the state in response to the malpractice crisis).

[27] U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REQUESTERS: MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 18 n.27 (Aug. 2003) [hereinafter IMPLICATIONS].

[28] *Id.* at 13-14. Specifically, the GAO confirmed that two of the five hospitals in the three counties along the Gulf Coast had reduced or lost ER on-call surgical coverage for some services. The GAO also confirmed that some physicians had stopped newborn delivery service, "creating access problems in certain rural communities." *Id.* at 14.

[29] *Id.* at 12.

best location and Jackson as the thirty-fifth.[30] One of the criteria used was the amount physicians pay for malpractice coverage.[31]

In the current debate, the fact that medical malpractice does occur and is more prevalent and costly than many realize has been largely overlooked. As concluded in a recent report by the Institute of Medicine, between 44,000 and 98,000 people die in hospitals each year as the result of preventable medical errors.[32] In addition, the total estimated annual cost of preventable adverse events resulting from medical errors in hospitals is between $17 billion and $29 billion.[33] When considering the implementation of tort reform, it is critical to remember that medical malpractice liability serves the important functions of compensating victims and deterring medical malpractice.[34]

The politicization and exaggeration of the medical malpractice crisis have caused the public debate to be one-sided and oversimplified, leading many to overlook the extent to which other factors, such as decreased investment income, increased reinsurance costs, decreased competition, and the cyclical nature of the insurance market, have contributed to the crisis.[35] The oversimplification of the crisis appears to have given many politicians and medical providers an unrealistic confidence that enacting additional tort reform will remedy the current crisis and prevent future ones.

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[30] *Our Top 75 Places to Run a Medical Practice*, MODERN PHYSICIAN, Oct. 1, 2003, *available at* http://www.modernphysician.com.

[31] *Id.* In addition to the apparent exaggeration of the state's medical malpractice "crisis," there are also indications that the state's civil justice system is not as unfriendly to small businesses as claimed. In 2001, 2002 and 2003 Mississippi was ranked in the top ten states for small businesses by the Small Business Survival Committee. In addition, Mississippi ranked eighth in the nation in 2003 in small business growth. Becky Gillette, *Small Business Climate in Mississippi Ranked One of the Best*, MISS. BUS. J., Jan. 5, 2004, at 14.

[32] COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM 27, 30-31 (Linda T. Kohn et al. eds, 2000).

[33] *Id.* at 27.

[34] KENNETH S. ABRAHAM, THE FORMS AND FUNCTIONS OF TORT LAW 14-19 (2d ed. 2002).

[35] MULTIPLE FACTORS, *supra* note 1, at 15.

Another obstacle faced in attempting to diagnose and respond to the current crisis is the difficulty in obtaining current objective data concerning the number of malpractice claims, the amount of jury verdicts in those cases that go to trial, the amount of settlements in cases which are not tried or which are settled after a jury verdict and the degree to which such settlements and/or judgments are based on noneconomic damages.[36]

Although the current crisis and related tort reform movement are not limited to Mississippi, in order to closely evaluate what is affecting the insurance market within Mississippi, it is necessary to evaluate many factors which are specific to Mississippi, such as the applicable common and statutory law, the tort reform legislation passed in 2002, the frequency and severity of claims within the state, the financial performance of the largest malpractice insurer in the state and the current rates for malpractice insurance in the state.[37] This Article closely examines several of these factors in an attempt to discern whether additional tort reform measures, particularly a $250,000 cap on noneconomic damages or a mandatory medical review panel, are necessary and whether the likely benefits of such measures justify curtailing patients' existing rights to civil justice.[38] This article focuses specifically on medical malpractice law and does not address the broader issue of whether additional general tort reform is necessary.

To provide the necessary foundation for analyzing the

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[36] *Id.* at 22-23.

[37] All but six states have been designated as crisis states by the AMA. Am. Med. Ass'n, *supra* note 5, at 7. Various federal tort reform bills have been introduced but have not yet been passed. *See, e.g.,* H.R. 5, 108th Cong., 1st Sess. (2003) (containing a $250,000 cap on noneconomic damages); S. 2207, 108th Cong., 2d Sess. (2004) (containing a similar cap). Given that many state-specific factors affect malpractice premiums and claims, it is difficult to make broad generalizations about the national medical malpractice insurance crisis. MULTIPLE FACTORS, *supra* note 1, at 37.

[38] As discussed *supra* note 21, this Article was written prior to the passage of House Bill 13 in June of 2004. Thus, the Article examines whether, in light of the substantial legislative reform previously enacted in 2002 and the judicial reforms implemented in recent years, it was necessary to pass additional medical malpractice tort reform legislation in 2004.

current crisis, Part I of this Article briefly explains how insurers calculate the income they earn and the rates they charge. It also examines historical aggregated industry-wide data to demonstrate the cyclical nature of the insurance market and the manner in which fluctuating interest rates and capital markets affect insurers' ratemaking.

Part II reviews the statutory reform measures enacted by the Mississippi Legislature in 2002 and 2003 as well as numerous reforms recently implemented by the Mississippi Supreme Court and suggests that, with respect to medical malpractice litigation, these reforms are substantial in nature and address many of the perceived problems with Mississippi's civil justice system.

Part III examines several sources of objective data relevant to the current medical malpractice liability insurance market within Mississippi, including: (i) various statements concerning the financial performance of Medical Assurance Company of Mississippi (MACM), the largest medical malpractice insurer in Mississippi; (ii) the public data file made available by the National Practitioner Data Bank, a national repository of reports concerning malpractice payments made on behalf of physicians; (iii) annual rate surveys published by Medical Liability Monitor, a company which reports malpractice rates charged by insurers for coverage in Mississippi and throughout the nation and (iv) reports prepared by Mississippi's Administrative Office of the Courts, which is charged with compiling information concerning all civil cases filed in the state.

The MACM data indicates that: (i) MACM's net income and surplus have been greatly affected by fluctuating interest rates and capital markets in recent years; (ii) MACM, which is not subject to regulation limiting its investments, invests a much higher percentage of its assets in the stock market than most other insurers; (iii) from 1998 to 2002, MACM's annual net investment gain decreased by more than $13 million from approximately $20.8 million in 1998 to approximately $7.1 million in 2002; (iv) in 2002, MACM experienced $8.7 million in unrecognized capital losses and almost $300,000 in recognized capital losses, which losses significantly contributed to

MACM's decrease in surplus; (v) although MACM's gross paid losses increased from 1998 to 2001, its gross paid losses decreased by almost twenty-seven percent from 2001 to 2003 and (vi) although the number of claims filed with MACM increased in 2002 and 2003, most of the increase resulted from the joinder of multiple medical malpractice claims in mass tort cases involving pharmaceutical defendants, which joinder has been severely curtailed pursuant to the Mississippi Supreme Court's recent decision in *Janssen Pharamceutica, Inc. v. Armond*.[39] While the MACM data provides little evidentiary support for legislative tort reform measures beyond those enacted in 2002, it does suggest that the Mississippi Legislature should consider whether statutory limitations on MACM's investments would decrease the volatility in MACM's income and surplus, and thereby decrease the volatility in MACM's premiums.

The National Practitioner Data Bank data reveals that: (i) the 2003 mean and median payments made on behalf of Mississippi physicians were less than the 2003 mean and median payments made on behalf of physicians nationwide; (ii) from 1997 to 2003, the mean and median payments made on behalf of physicians nationwide increased at a faster rate than the mean and median payments made on behalf of Mississippi physicians; (iii) more payments exceeding $2 million were made on behalf of Mississippi physicians from 1994 to 1998 than from 1999 to 2003; (iv) the total amount paid on behalf of Mississippi physicians decreased by more than twenty-five percent from 2001 to 2003; (v) the number of payments made on behalf of Mississippi physicians in 2003 was substantially lower than the number of such payments made in 2001 and in 2002 and (vi) a substantial percentage of the total amount paid on behalf of Mississippi physicians has been paid on behalf of a relatively small number of physicians for whom multiple payments have been made. Thus, the data establishes that mean and median physician malpractice payments in Mississippi are lower than mean and median physician mal-

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[39] 866 So. 2d 1092 (Miss. 2004). For a detailed discussion of *Janssen*, see *infra* notes 168-78 and accompanying text.

practice payments nationwide and that in 2003, there was a substantial decrease in the total amount paid on behalf of Mississippi physicians as well as a significant decrease in the total number of payments made – evidence which does not support additional tort reform legislation.

The rate surveys published by Medical Liability Monitor demonstrate that: (i) in many instances, the 2003 range of reported rates charged by malpractice insurers for coverage in Mississippi is comparable to or lower than the range of reported rates charged by insurers for coverage in other states where tort reform measures were enacted several years ago and (ii) rates for coverage in some states which enacted tort reform many years ago have increased substantially in recent years. In light of this information, it is not at all clear that additional tort reform measures would prevent substantial rate hikes during future hard markets.

Finally, the information obtained from the Administrative Office of the Courts (AOC) indicates that: (i) the number of filed medical malpractice cases spiked in 2002, due in part to a rush to file claims in late 2002 in an effort to avoid the tort reform legislation which applies to cases filed on or after January 1, 2003 and in part to an increase in the number of mass tort cases involving claims against pharmaceutical defendants and physicians; (ii) in 2003, the number of filed medical malpractice cases declined dramatically to 252, substantially fewer than the number of medical malpractice cases filed in earlier years; (iii) in a majority of Mississippi's counties, fewer than two medical malpractice cases were filed in 2003 and (iv) in 2003, there were only eleven Mississippi counties in which more than four malpractice cases were filed. Thus, the AOC data, which indicates that fewer medical malpractice cases were filed in 2003 than in any year from 1998 to 2002, fails to provide an adequate evidentiary basis for additional tort reform measures.

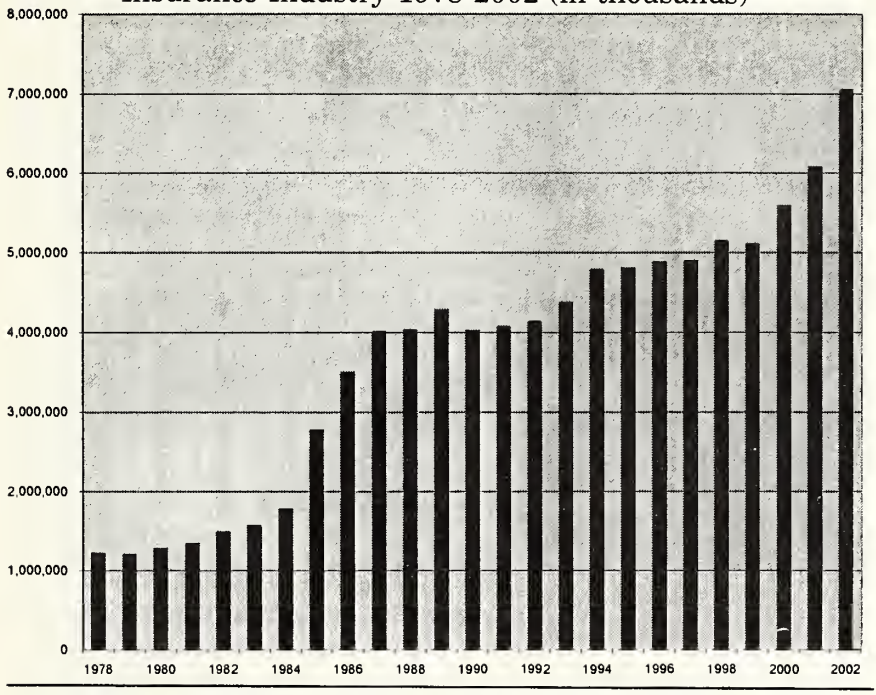
Based upon an evaluation of the above referenced data, and in light of the tort reform legislation enacted in 2002 as well as the recent judicial reforms, this Article concludes that there is little evidence indicating that additional tort reforms, particularly a $250,000 cap on noneconomic damages or a

medical review panel, will reap benefits sufficient to justify their imposition.

I. Examination of Accounting and Ratemaking by Insurers and Historical Aggregated Industry Data

As Chart 1 demonstrates, from 1999 to 2002, net premiums written by the national medical malpractice insurance industry increased from approximately $5.1 billion to more than $7.04 billion. That substantial premium increase is similar to the premium increases during previous medical malpractice insurance crises. For example, from 1984 to 1986, the net premiums written by the medical malpractice industry nearly doubled, rising from $1.77 billion to $3.49 billion.[40]

Chart 1. Net Premiums Written by Medical Malpractice Insurance Industry 1978-2002 (in thousands)[41]



[40] A.M. Best Co., Best's Aggregates and Averages: Property-Casualty 91 (1988).

[41] *See* A.M. Best Co., Best's Aggregates and Averages: Property-Casualty 91 (1988) (data for 1978 to 1987); A.M. Best Co., Best's Aggregates and Aver-

To better understand the causes of the recent increase in premiums in Mississippi and nationwide, one must have a rudimentary understanding of the manner in which malpractice insurers calculate income and set rates. An insurer's net income is primarily determined by its underwriting profit and its net investment gain. In most of the past twenty-five years, the medical malpractice industry has incurred an underwriting loss which has been offset by investment gain.[42]

Formula 1. Net Income

Net Income = Underwriting Profit + Net Investment Gain

When calculating underwriting profit, an insurer must first calculate its net premiums earned and then subtract its incurred losses, incurred loss adjustment expenses (LAE) and

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AGES: PROPERTY-CASUALTY 157 (1993) (data for 1988 to 1992); A.M. BEST CO., BEST AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 276 (2002) (data for 1993 to 2001); A.M. BEST CO., BEST'S AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 356 (2003) (data for 2002) [collectively hereinafter AGGREGATES AND AVERAGES]. A.M. Best Company obtains the Annual Statements which insurers file with the insurance regulators in the states in which they are licensed and aggregates all of the data contained therein. The Annual Statement is the primary source of financial information concerning an insurance company. The form for the Annual Statement, known as the Convention Blank, was created by the National Association of Insurance Commissioners (NAIC) and incorporates a balance sheet, income statement, cash flow statement and numerous schedules. State regulators use these filings, as well as other periodic filings and examinations, to ensure that insurance companies remain solvent. The Annual Statements are completed according to statutory accounting principles (SAP), which are more conservative than generally accepted accounting principles (GAAP). SAP-based financial statements valuate assets and liabilities on a liquidation basis, as opposed to GAAP-based financial statements which valuate assets and liabilities on a going-concern basis. SAP are employed to further the states' interest in ensuring that insurance companies remain solvent. SEAN MOONEY ET AL., INS. INFO. INST., BASIC CONCEPTS OF ACCOUNTING AND TAXATION OF PROPERTY/CASUALTY INSURANCE COMPANIES 4-5 (4th ed. 1995) [hereinafter BASIC CONCEPTS]; NAT'L ASS'N OF INS. COMM'RS, INSURANCE REGULATORY INFORMATION SYSTEM (IRIS) 1-2 (Property/Casualty ed. 2002) [hereinafter IRIS]; TERRIE E. TROXEL & GEORGE E. BOUCHIE, PROPERTY-LIABILITY INSURANCE ACCOUNTING AND FINANCE 2-3, 27-28 (4th ed. 1995). A.M. Best Company's aggregated data does not include information concerning some smaller mutual companies which do business in a limited area.

[42] *See infra* notes 54-61 and accompanying text.

other incurred operating expenses.[43] Losses include the amounts paid to satisfy judgments and settle claims.[44] LAE include fees and salaries paid to claims adjusters, attorneys and investigators, as well as costs incurred by them in resolving claims.[45] Other operating expenses include salaries, commissions, rent and overhead.[46]

Formula 2. Underwriting Profit

Underwriting Profit = Net Premiums Earned - Losses Incurred - LAE Incurred - Other Underwriting Expenses Incurred

In long-tail lines of insurance such as medical malpractice liability, it takes many years for an insurer to resolve all of the claims arising from coverage provided during an accounting year.[47] The insurer must therefore estimate the amount of losses and LAE it will have to pay in future years and establish reserve accounts to cover these liabilities.[48] When calculating reserves, insurers retain a significant amount of discretion.[49] The accuracy of insurers' reserve calculations can only be discovered over time, as the actual losses and LAE develop.

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[43] BASIC CONCEPTS, *supra* note 41, at 11-13. In accordance with statutory accounting principles (SAP), an insurer is only permitted to treat as income that portion of a premium which it has earned. The remainder is unearned premium which is treated as a liability and placed in a reserve. *Id.* at 11-13, 22; TROXEL & BOUCHIE, *supra* note 41, at 117-19. For example, if ABC Insurance Co. sells Dr. X a liability policy for $20,000 which provides claims-made coverage for July 1, 2003 through June 30, 2004, ABC has only earned $10,000 of the total premium by December 31, 2003. The remaining $10,000 of premium is treated as a liability and is placed in ABC's unearned premium reserve. An insurer's net premiums earned are equal to its gross premiums earned less the earned premiums the insurer has ceded to reinsurers as payment for reinsurance.

[44] BASIC CONCEPTS, *supra* note 41, at 29.

[45] *Id.* at 37.

[46] *Id.* at 53.

[47] The "tail" is the period of time between the incident that triggers coverage and claim settlement. TROXEL & BOUCHIE, *supra* note 41, at 91.

[48] *Id.* at 90-92, 112.

[49] *Id.* at 93-94.

In each accounting year, an insurer must calculate and report its incurred losses and incurred LAE. Incurred losses include all losses actually paid during the accounting year, whether paid pursuant to an older policy or one issued during the accounting year, and any net changes in its loss reserves from the end of the previous year to the end of the accounting year.[50] Similarly, an insurer's incurred LAE includes the LAE actually paid during the accounting year and any net change in its LAE reserves.[51] After calculating incurred losses and incurred LAE, an insurer must calculate its incurred underwriting expenses, the substantial majority of which are paid during the accounting year.[52]

If an insurer inaccurately estimates incurred losses or incurred LAE, its calculation of underwriting profit for the accounting year will not accurately reflect the company's underwriting results. For example, when an insurer overestimates its loss reserves and/or LAE reserves, that overestimation distorts the accuracy of its income statement for that year, causing its stated income to be lower than it actually is. Such overestimation defers income recognition and related income tax to future years, distorts an insurer's loss experience record and can unnecessarily cause future premiums to increase. Conversely, when a company understates its reserves, its profits will be overstated, which may cause premiums to be set at artificially low levels. Inaccurate estimation of reserves not only distorts the accuracy of the income statement for the current accounting year, it also distorts the accuracy of the income statement in the years in which those reserves are adjusted. For example, when an insurer has overestimated reserves in prior accounting years, it will be forced to reduce its reserves in later accounting years as the loss and LAE reserves develop favorably. This will cause the insurer's performance in the later accounting years to appear more profitable than it really is.[53]

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[50] BASIC CONCEPTS, *supra* note 41, at 53; TROXEL & BOUCHIE, *supra* note 41, at 46.

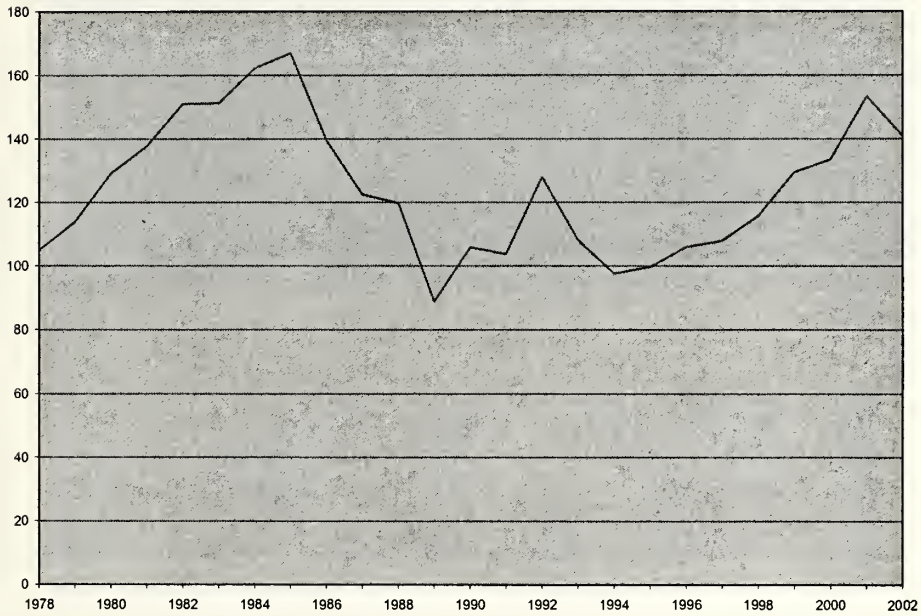
[51] TROXEL & BOUCHIE, *supra* note 41, at 46.

[52] BASIC CONCEPTS, *supra* note 41, at 53.

[53] *Id.* at 29; TROXEL & BOUCHIE, *supra* note 41, at 10, 92-94. For further ex-

If an insurer earns sufficient net premiums to cover all its incurred losses, incurred LAE, incurred underwriting expenses and any dividends it chooses to pay, then the insurer recognizes an underwriting profit. A combined ratio after dividend of less than 100 indicates underwriting profit.[54] As is shown in Chart 2, the medical malpractice insurance industry has recognized an underwriting profit in only three years since 1978.[55]

Chart 2. Medical Malpractice Insurance Industry
Combined Ratio After Dividend (1978-2002)[56]



planation and demonstration of how overestimation and underestimation of incurred losses and incurred LAE distort income, see *infra* Appendix A.

[54] For example, a ratio of 95 indicates that for every $100 of premium, the industry incurred $95 in losses, LAE, other underwriting expenses and dividends.

[55] The combined ratio after dividend was below 100 in 1989, 1994 and 1995.

[56] *See* AGGREGATES AND AVERAGES, *supra* note 41.

Even though the medical malpractice insurance industry typically loses money on its underwriting business, it has usually been able to offset its underwriting loss with investment gain. Investment gain consists primarily of investment income in the form of interest or dividends, and recognized capital gains or losses.[57]

Formula 3. Net Investment Gain

Net Investment Gain = Net Investment Income + Net Realized Capital Gain (Loss)

Obviously, changing interest rates and fluctuating capital markets affect an insurer's ability to offset underwriting loss with investment gain. As investment gain decreases, an insurer must increase premiums in order to maintain overall profitability.[58] As Chart 3 demonstrates, in 2002, the ratio of investment gain to net earned premiums was at its lowest point since 1976, indicating that it is currently much more difficult for medical malpractice carriers to offset underwriting losses with investment gain sufficient to realize a positive operating profit.

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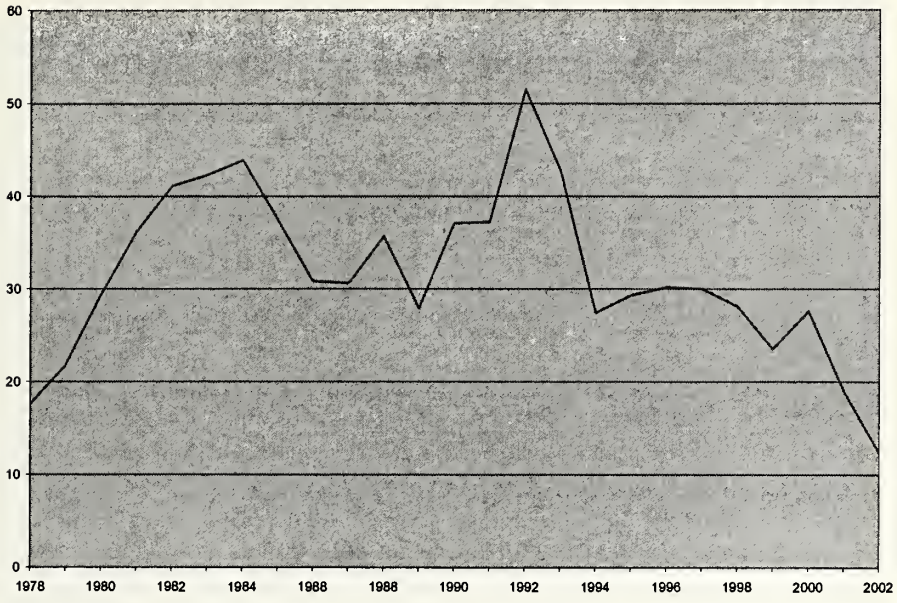
[57] BASIC CONCEPTS, *supra* note 41, at 53, 56.
[58] MULTIPLE FACTORS, *supra* note 1, at 25-26.

Chart 3. Medical Malpractice Insurance Industry
Ratio of Investment Gain to Net Premiums Earned
(1978-2002)[59]



To calculate overall net income, an insurer simply adds its net underwriting profit, net investment gain and net other income. As demonstrated in Chart 4 below, the medical malpractice insurance industry's profitability is cyclical and is dependent on both underwriting results and investment gain.[60]

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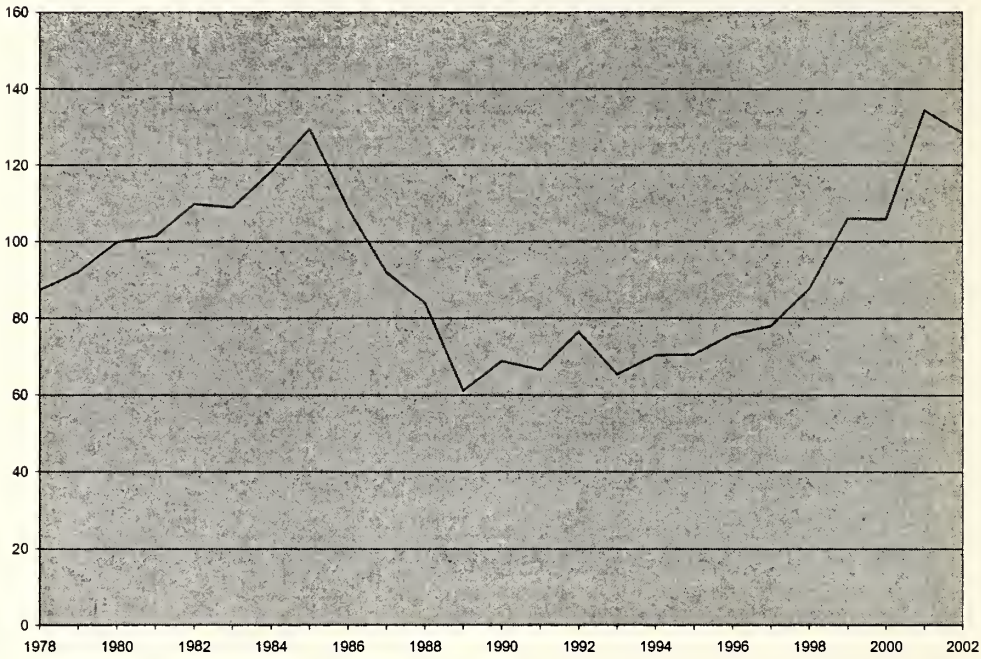
[59] *See* AGGREGATES AND AVERAGES, *supra* note 41. The chart reflects the ratio of investment gain attributable to insurance transactions and other income to net earned premiums. A.M. BEST CO., BEST'S AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 263 (1999). In addition to investment income, insurers report miscellaneous income and expenses not related to underwriting or investment activity as "other income." Other income includes finance or service charges not included in premiums as well as write-offs for uncollectible premiums. BASIC CONCEPTS, *supra* note 41, at 56, TROXEL & BOUCHIE, *supra* note 41, at 168. Basically, a ratio of 10 indicates that for every $100 of net earned premium, an insurer earned $10 in investment gain.

[60] BASIC CONCEPTS, *supra* note 41, at 41.

Chart 4. Medical Malpractice Insurance Industry
Overall Operating Ratio (1978-2002)[61]



An insurer's overall profitability in a given year directly affects its surplus, which is equal to the value of its assets less the value of its liabilities.[62] A net profit increases an insurer's surplus, while a net loss decreases an insurer's surplus.[63]

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[61] *See* AGGREGATES AND AVERAGES, *supra* note 41. The overall operating ratio reflects income after dividends have been paid but before taxes have been paid. A.M. BEST CO., BEST'S AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 263 (1999).

[62] An insurer's balance sheet is similar to most corporate financial statements in that it lists the assets and liabilities of the insurer. An insurer's assets consist primarily of the premiums it has received and invested in income-producing investments such as bonds, stock, real estate and other investments. An insurer's liabilities consist primarily of its unearned premium reserve, its loss reserve and its LAE reserve. BASIC CONCEPTS, *supra* note 41, at 21, 41.

[63] *Id.* at 56.

Although operational profitability is typically the most significant source of surplus growth, unrecognized capital gains are another source of surplus growth.[64] Unrecognized capital losses, however, decrease surplus.[65] Thus, fluctuating capital markets may affect not only an insurer's net profit in a given year, but also its surplus. An insurer's surplus provides a financial buffer to ensure the company's solvency in the event of fluctuating investment yields and underwriting results.[66] The amount of an insurer's surplus dictates the quantity of insurance it can sell because the need to maintain adequate surplus constrains an insurer's capacity to write new premiums.[67]

Setting rates in a long-tail liability line of insurance such as medical malpractice is not an easy task because a claim

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[64] A.M. BEST CO., BEST'S AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 89 (1999).

[65] BASIC CONCEPTS, *supra* note 41, at 54. Insurers must report changes in surplus on their Annual Statement. The NAIC considers any decrease in surplus greater than ten percent to be unusual, requiring further examination by regulators. IRIS, *supra* note 41, at 5, 20.

[66] TROXEL & BOUCHIE, *supra* note 41, at 33.

[67] All states require insurers to maintain minimum levels of surplus. In addition to these required minimum levels of surplus, state regulators also consider the ratio of an insurer's net premiums written to its surplus in order to determine whether the safety buffer created by the surplus is sufficient, given the quantity of insurance sold. *Id.* at 227; BASIC CONCEPTS, *supra* note 41, at 39. So, for example, if ABC Insurance Co. wrote $1,000,000 in net premiums in 2003 and had a year-end surplus of $500,000, its premiums to surplus ratio would be 2:1. The NAIC considers any ratio above 3:1 to be outside the usual range. The NAIC, however, recommends that insurers in long-tail liability lines maintain greater surplus because it is more difficult to accurately predict losses in such lines and because they experience a higher degree of variability from year to year. IRIS, *supra* note 41, at 5, 9-10. A more conservative rule, known as Kenney's rule, suggests that the net premiums written to surplus ratio should not exceed 2:1. TROXEL & BOUCHIE, *supra* note 41, at 185. As an insurer writes additional premiums, the premiums to surplus ratio increases, not only because unearned premiums are treated as liabilities which reduce surplus, but also because SAP requires the insurer to immediately recognize expenses incurred in selling the policy, such as agents' commissions, printing and mailing fees and premium taxes, thereby further reducing the surplus. This accounting requirement can, at least in the short run, significantly decrease an insurer's surplus if it is writing new business. *Id.* at 12-13; BASIC CONCEPTS, *supra* note 41, at 26. For data concerning the ratio of net premiums written to surplus, see *supra* note 212 and accompanying text, including Table 3.

covered by a current policy may not be settled or resolved in court for many years. Thus, liability insurers are forced to predict future losses in order to calculate premiums for current coverage. In order to make such predictions, insurers rely on historical data concerning policies sold in the past. Insurers would prefer to use information concerning policies sold most recently because more recent data is likely to be more accurate. Given that it takes many years to resolve claims, however, complete data concerning the policies sold in recent years is unavailable. Thus, insurers and their actuaries use older, more complete data to discern the payout pattern over time, and then, using an appropriate multiple, "develop" the most recent, but incomplete data. In addition to developing the loss data, insurers also consider various trends such as monetary inflation, legal changes, changes in the frequency and severity of claims and other factors. Based on these factors, insurers and their actuaries use another multiple to "trend" the data that has already been developed.[68]

Once an insurer has estimated its ultimate expense, including loss payments, defense costs and underwriting expenses, it must also consider the investment income it expects to earn. When an insurer anticipates earning a relatively high investment return, it sets relatively low insurance rates. As an insurer's investment return decreases, however, it must raise rates.[69] An insurer must attempt to set a rate that will allow it to remain competitive and also earn a reasonable profit.[70] If an insurer charges too much, it risks loosing premium volume to competitors. Conversely, if an insurer charges too little, it risks not only financial loss but also insolvency.

Insurers group physicians into specialty classes which

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[68] For general discussions of ratemaking, see Angoff, *supra* note 23, at 404-06; Chris Burkhalter et al., *Exactly How Are Your Rates Determined?*, THE MACM MONITOR, Jan. 2004, at 5, *available at* http://www.macm.net/pdf/mon303.pdf (last visited Apr. 10, 2004); Ins. Servs. Office, *Advisory Prospective Loss Costs*, *available at* http://www.iso.com/products/2100/prod2131.html (last visited Mar. 20, 2004).

[69] MULTIPLE FACTORS, *supra* note 1, at 25-26.

[70] Mutual nonprofit insurance companies owned by physicians now comprise a significant part of the market and may be able to charge lower premiums given that they do not have shareholders who expect to earn a profit. *Id.* at 5.

pose different levels of risk. For example, neurosurgeons may fall into one classification, general surgeons into another, general practitioners into another, and so on. Most insurers set rates on a geographic basis, establishing the same base rate for an entire state or for a specific geographic region within a more populous state.[71] Rates for medical malpractice coverage in Mississippi are the same throughout the state because the relevant risk pools aren't large enough to divide the state into separate geographic regions.[72] Insurers typically set uniform base rates for all insureds in the class using the claims experience of the entire class rather than the experience of each individual physician. Insurers may then offer some physicians discounts and assess others surcharges based on individual considerations such as claims history and involvement in risk-management programs.[73] When insurers are setting rates for risk pools with a small number of policyholders, the predictive value of the data is less reliable and may necessitate charging a higher rate. This may be particularly true for insurers setting rates for a narrow specialty with few practicing physicians in a state or region.[74]

Once an insurer has determined an appropriate rate, it must comply with any rate regulation within the state in which it is doing business.[75] Malpractice insurance rates are

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[71] *Id.* at 7; *see, e.g., 2003 Annual Rate Survey*, MED. LIABILITY MONITOR, Oct. 2003 (listing insurers' rates by state and by regions within states).

[72] *The Joint Study Comm. on the Civil Justice Sys. Hearing*, 2002 Leg., 1st Ex. Sess. 281 (Miss. 2002) (testimony of Michael Houpt) [hereinafter Houpt Testimony].

[73] MULTIPLE FACTORS, *supra* note 1, at 7.

[74] *Id.* at 8.

[75] In most states, the Department of Insurance is charged with the obligation of ensuring that insurance rates are not "inadequate, excessive or unfairly discriminatory." The manner in which this obligation is fulfilled varies from state to state. Most states originally enacted "prior approval" laws, requiring insurers to file their rates and obtain approval prior to using them. Other states enacted "file and use" laws authorizing insurers to implement rate changes as soon as they were filed, but preserving the commissioner's right to disapprove such rates within a certain time period. More recently, many states have abandoned these methods in favor of open competition. Even in these states, however, the commissioner retains authority to regulate rates if the open market fails. A few states, most notably California, have moved in the opposite direction, enacting more restrictive

not heavily regulated in Mississippi.[76] In other states, such as California, rates are more heavily regulated.[77]

Given these basics of insurance accounting and ratemaking, it is easier to understand how the cyclical nature of the insurance industry contributed to the past and current crises. During "soft markets," insurers sell policies at low rates in order to maintain market share to obtain premium dollars to invest; coverage is relatively available and affordable. When interest rates decline, insurers' overall operating ratios deteriorate, causing insurers to retrench. During "hard markets," insurers not only raise rates in order to maintain profitability, they also tighten their underwriting standards.[78] The cycle is much more volatile in medical malpractice insurance because it has one of the longest "tails." As interest rates increase, medical malpractice insurers can af-

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regulation, as discussed *infra* note 77. For a general discussion of rate regulation, see ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 114-18 (3d ed. 2002). For a more detailed discussion, see Scott E. Harrington, *Insurance Rate Regulation in the 20th Century*, 19 J. INS. REG. 204 (2000).

[76] Although the Mississippi Department of Insurance has authority to regulate the rates of admitted insurers, it does not usually regulate such rates. IMPLICATIONS, *supra* note 27, at 37; *see also* JOINT LEGISLATIVE COMM. ON PERFORMANCE EVALUATION AND EXPENDITURE REVIEW, MISSISSIPPI INSURANCE DEPARTMENT: IT'S EFFECTIVENESS IN REGULATING THE STATE'S INSURANCE INDUSTRY 16-17 (Nov. 9, 1999) (finding that the Mississippi Department of Insurance failed to submit fifty-nine percent of the 1998 property-casualty rate filings for actuarial review). MACM, which insures thousands of physicians in Mississippi, is exempt from rate regulation as discussed *infra* notes 199-201 and accompanying text.

[77] In 1988, California's voters approved Proposition 103, mandating rate rollbacks in several lines of insurance as well as prior approval of rates. Proposition 103 is now codified at CAL. INS. CODE § 1861 (West 2004). Recently, SCPIE Indemnity Co., one of the largest medical malpractice insurers in California, requested a 15.6% rate increase, which the California Commissioner reduced to 9.9% in September of 2003. Kenneth Reich, *Garamendi Cuts Malpractice Insurance Hike*, L.A. TIMES, Sept. 4, 2003, at B10. SCPIE filed a second request for an additional increase of 8.9%, but withdrew the request after consumer advocates challenged the request and demanded a hearing. The Found. for Taxpayer and Consumer Rights, *FTCR Stops '04 Medical Malpractice Rate Hike by CA's Largest Insurer, Saving Doctors $11 Million* (Dec. 19, 2003), *available at* http://www.consumerwatchdog.org/insurance/pr/pr003914.php3 [hereinafter FTCR].

[78] J. David Cummins et al., *Cycles and Crises in Property/Casualty Insurance: A Background Discussion*, *in* CYCLES AND CRISES IN PROPERTY/CASUALTY INSURANCE: CAUSES AND IMPLICATIONS FOR PUBLIC POLICY 1, 2-3 (J. David Cummins et al. eds., 1991); MULTIPLE FACTORS, *supra* note 1, at 33-34.

ford to cut prices more than other insurers because medical malpractice insurers will be able to invest the premium dollars at high interest rates for many years before paying claims.

During periods when interest rates are relatively high, insurers must compete for business and may offer coverage at depressed rates. It was no secret that insurers' losses were gradually increasing from 1975 to 1983, when interest rates were also reaching historic levels.[79] Instead of gradually raising premiums to reflect the increasing losses, however, insurers engaged in a brutal price war, offering insurance at depressed rates which were below cost in many instances.[80] Many industry observers noted that insurers cut prices beyond what was reasonable.[81] Not only did this drastic price cutting contribute to the large underwriting losses experienced by the industry during the crisis years, but it also meant that in order to return to profitability, the swing in premiums was much more drastic, given that many policies were being sold

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[79] SEAN F. MOONEY, CRISIS AND RECOVERY: A REVIEW OF BUSINESS LIABILITY INSURANCE IN THE 1980S, at 5-15 (1992) (noting that in the general liability market, paid losses increased in every year from 1978 to 1983 while total premiums declined, indicating that the industry was highly price competitive). Interest rates peaked in 1980 when the prime rate reached 21.5%. By 1985, the prime rate had dropped to 10.5%. Federal Reserve Bank of New York, Prime Rate as It Changed 1929 to Present, *available at* ftp://ftp.ny.frb.org/prime/Prime.txt (last updated June 27, 2003).

[80] DOJ REPORT, *supra* note 22, at 21-27. Commenting on the price war, the Maryland Insurance Commissioner stated that "[g]ood, sound, traditional underwriting practices in properly pricing a particular risk were cast to the wind in order to capture market share." Nancy Nichols, *The Manufacturing of a Crisis*, THE NATION, Feb. 15, 1986, at 173.

[81] Cummins et al., *supra* note 78, at 3. As an explanation for why insurers might price policies at rates that were too low to cover costs, it has been suggested that inexperienced insurers, such as those entering new markets, might price coverage too low, thereby putting downward pressure on rates. Such an insurer might suffer the "winner's curse," whereby it would capture a large share of the market, grow relatively fast, but then be forced to strengthen reserves. In addition, there may be some insurers that are excessive risk-takers, induced by the short-term profits generated by high interest rates. Scott E. Harrington & Patricia M. Danzon, *Price-Cutting in Liability Insurance Markets*, *in* CYCLES AND CRISES IN PROPERTY/CASUALTY INSURANCE: CAUSES AND IMPLICATIONS FOR PUBLIC POLICY, *supra* note 78, at 122, 176-77.

below cost during the soft market.[82] The excessive competition of the early 1980s contributed to insurers' deteriorating underwriting results in 1984 and 1985, as insurers were forced to strengthen their reserves to realistic levels.[83] At the same time, interest rates declined.[84] Even a small decrease in interest rates can cause a relatively large increase in premiums, given that the insurer must compensate for the lost return over a period of several years.[85]

In addition to the premium volatility that can be caused by the underwriting cycle, shocks to the industry's capacity can exacerbate or prolong a hard market. Any constraint on capacity places upward pressure on premiums and also decreases overall availability.[86] Capacity was constrained during the 1985-1986 crisis in large part due to a tighter reinsurance market, which hampered insurers' ability to create surplus through reinsurance.[87] This constraint probably pushed premiums even higher. Thus, at a time when insurers were drastically increasing their premiums written and thereby decreasing capacity, their ability to increase surplus was diminished by deteriorating underwriting results, decreasing investment income and a tighter reinsurance market. The capacity constraint theory would explain why some insurers, such as St. Paul, stopped issuing new policies during the 1985-1986 crisis.[88]

In adjusting premiums during the previous crisis, howev-

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[82] DOJ REPORT, *supra* note 22, at 22; MULTIPLE FACTORS, *supra* note 1, at 35.

[83] DOJ REPORT, *supra* note 22, at 21-22.

[84] See *supra* note 79.

[85] Abraham, *supra* note 23, at 401; Mooney, *supra* note 79, at 9 n.4.

[86] Abraham, *supra* note 23, at 400.

[87] In the years preceding the crisis, numerous insurers entered the reinsurance market, many of whom where captive insurers lured into the reinsurance market in order to retain certain tax advantages. Many of the captives sold reinsurance at deflated premiums, which led to deteriorating underwriting results, forcing many captives into insolvency. European companies, less willing to offer reinsurance, may have been responding to the relative strength of the U.S. dollar. Reinsurers were also probably responding to a perceived increased risk in the ceded business. Abraham, *supra* note 23, at 400; Winter, *supra* note 23, at 475.

[88] At the time, St. Paul Insurance Co. was the largest provider of medical liability insurance to doctors, providing coverage to twenty percent of physicians. DOJ REPORT, *supra* note 22, at 7.

er, medical malpractice insurers greatly overestimated their future losses. Analyzing the losses and LAE as they actually developed, it is clear that the premium increases implemented by insurers in late 1985 and 1986 far outpaced any actual increase in losses or LAE. After nine years of development, the medical malpractice insurance industry reported $2.13 billion in net losses and LAE incurred as the result of policies for which premiums were earned in 1981.[89] After nine years of development, the industry reported $2.75 billion in net losses and LAE incurred as the result of policies for which premiums were earned in 1986.[90] Thus, from 1981 to 1986, losses and LAE incurred as the result of policies for which premiums were earned during the accounting year increased by only 29%, not even close to the 159% increase in net premiums earned by the industry over the same period.[91] In retrospect, the substantial rate hikes of late 1985 and 1986 led to substantial profit for the insurers.[92] After nine years of development, medical malpractice insurers reported earning $3.57 billion in net premiums for coverage provided in 1986 and incurring only $2.75 billion in losses and loss expenses as a result of that coverage.[93] Thus, it is likely that medical malpractice insurers actually earned significant underwriting profit from coverage provided in 1986, before one even considers the investment income that was also earned.

As insurers' losses and LAE incurred pursuant to policies sold in the late 1980s developed, insurers were forced to release a significant amount of their reserves, which had the effect of increasing their income in the early 1990s and encouraging new insurers to enter the market, thereby starting

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[89] A.M. BEST CO., BEST'S AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 97 (1991).

[90] A.M. BEST CO., BEST'S AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 120-21 (1996).

[91] A.M. BEST CO., BEST'S AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 91 (1988).

[92] Zimmerman & Oster, *supra* note 24 ("The combination of this so-called tort reform and the industry's rate increases [during the 1985-1986 crisis] turned malpractice insurance into a very lucrative specialty.").

[93] A.M. BEST CO., BEST'S AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 120-21 (1996).

the cycle anew.[94] From 1990 to 1998, the medical malpractice market was soft, characterized by stable rates and fierce competition.[95] During this period, insurers sold coverage at rates that were inadequate to cover claims.[96] New entrants to the market continued the price cutting in an attempt to gain market share.[97] Even as loss payments increased in the early and mid-1990s, insurers did not raise premiums because they were able to offset underwriting losses with investment gain. When interest rates declined and the stock market fell, however, those investment gains disappeared.[98] Some have suggested that insurers exaggerated the problem by purposefully overstrengthening reserves in recent years.[99] In addition to the problems caused by declining interest rates, falling equity markets, increasing claims costs and massive reserve strengthening, insurers faced increased rates for reinsurance in the wake of the terrorist attacks on September 11, 2001.[100] The increased cost of reinsurance constrained many

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[94] MULTIPLE FACTORS, *supra* note 1, at 34-35; Zimmerman & Oster, *supra* note 24.

[95] MULTIPLE FACTORS, *supra* note 1, at 33.

[96] *Id.*; Zimmerman & Oster, *supra* note 24 (concluding that "[a] decade of short-sighted price slashing led to industry losses of nearly $3 billion [in 2001]").

[97] Zimmerman & Oster, *supra* note 24 (noting that smaller insurers attempted to attract customers by undercutting some of the larger insurers, such as St. Paul, thereby causing premiums to fall in many areas).

[98] Jesse Eisinger, *Ahead of the Tape*, WALL ST. J., Feb. 5, 2003, at C1 ("With interest rates at 40-year lows, the companies are figuring out suddenly that their current reserves won't be able to grow into adequacy through the magic of compounded returns."); Zimmerman & Oster, *supra* note 24.

[99] Christopher Oster, *AIG Chief Rails at Tort Awards, and Cashes In*, WALL ST. J., May 8, 2003, at C1; Christopher Oster, *Property-Casualty Insurers' 4th-Period Charges to Boost Claims Reserves Don't Faze Investors*, WALL ST. J., Feb. 26, 2002, at C2 (noting that "[s]ome analysts say other companies may be building up bigger-than-necessary reserves in moves that could boost earnings years down the road" and suggesting that St. Paul's claims-reserves boost made in connection with its exit from the market was extremely conservative and probably exceeded any reserve requirements imposed by regulators).

[100] MULTIPLE FACTORS, *supra* note 1, at 32-33; Ronald Gass, *The New Reinsurance Market: Pricing Continues to Harden After a Dreadful Year*, TORT SOURCE, Spring 2002, at 3 (observing that the property-casualty reinsurance market "jumped at warp speed" from an extremely soft market to an extremely hard market as the result of the 9/11 attacks, Tropical Storm Allison, the St. Louis hailstorm, "increased loss costs and moderating investment returns, a bearish equity market [during which the reinsurance industry sustained $18 billion in un-

insurers' capacity, thereby explaining why many insurers stopped writing new policies and/or withdrew from unfamiliar markets.

The price wars, declining equity markets, declining interest rates and increasing reinsurance costs clearly had a great impact on St. Paul and Reciprocal of America, two of the largest medical malpractice insurers in Mississippi. Industry insiders observed that St. Paul, in order to gain market share, priced policies "far below where they should have been," lost money and determined to exit the market.[101] Reciprocal of America, which was taken over by regulators after it became insolvent, was impacted by the declining stock market and increasing reinsurance costs.[102] In addition, it appears that some of Reciprocal's problems may have resulted from wrongful conduct on the part of its leaders. Virginia's insurance commissioner has sued several of the individual insiders who controlled Reciprocal in federal court, alleging fraud, conspiracy, breach of fiduciary duties and secret deals designed to dupe regulators.[103] The medical malpractice market in Mississippi was largely affected by St. Paul's withdrawal from the market and by Reciprocal's decline into insolvency. MACM, the largest remaining insurer, could not fill the void; it had to stop writing new policies in 2003 because its surplus was insufficient to support growth.[104] This gave non-admitted surplus lines insurers the opportunity to sell coverage at high

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recognized capital losses] and declining interest rates").

[101] Joseph T. Hallinan, *St. Paul Gradually Will Pull Out of Malpractice-Insurance Sector*, WALL ST. J., Dec. 13, 2001 at B2. St. Paul conducted only a small percentage of its business in Mississippi.

[102] Dawn Chase, *Reciprocal of America Issues $100M Capital Call: Med-mal Claims, Lawyer Coverage at Risk*, VA. LAW. WKLY., Jan. 13, 2003 (stating that "[Reciprocal's] investment portfolio of primarily stocks and bonds took a beating" and that problems developed on the reinsurance side at the same time). Although Reciprocal was a large insurer in Mississippi, only 18.6% of its total business was in Mississippi. *Malpractice Insurer in Financial Trouble*, RICHMOND TIMES-DISPATCH, Jan. 9, 2003, at B2.

[103] Bill McKelway, *Insurance Empire Takes Hard Knocks in Court*, RICHMOND TIMES-DISPATCH, Nov. 16, 2003, at A1; David Ress & Bill McKelway, *Lawsuit Alleges Fraud at Insurer; The Complaint Accuses Reciprocal's Leadership of Profiting While the Firm Sank*, RICHMOND TIMES-DISPATCH, Nov. 14, 2003, at A1.

[104] *See infra* notes 212-16 and accompanying text.

prices that were probably not competitive.[105] Thus, it is evident that the insurance underwriting cycle, insurers' excessive price-cutting during the soft market and considerable reserve strengthening during the hard market, as well as a much tighter reinsurance market, were factors which greatly contributed to the current medical malpractice crisis in Mississippi and nationwide.

II. EXAMINATION OF MISSISSIPPI LAW GOVERNING MEDICAL MALPRACTICE CASES, INCLUDING RECENT STATUTORY AND JUDICIAL REFORMS

In order to gain an even better understanding of what caused the current medical malpractice liability crisis in Mississippi and to determine the extent to which Mississippi's civil justice system caused or contributed to the crisis, it is necessary to review the Mississippi law which governs medical malpractice cases as well as the numerous statutory and judicial reforms which have recently been implemented.

A. Common Law Governing Medical Malpractice

The current medical malpractice liability insurance crisis cannot be attributed to Mississippi's substantive common law governing medical malpractice. Mississippi's substantive law governing medical malpractice is substantially similar to or more conservative than the law applied in a majority of jurisdictions. Moreover, there have been no recent substantive developments expanding liability on the part of health care providers.[106] In the 1985 landmark case of *Hall v. Hilbun*,

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[105] MULTIPLE FACTORS, *supra* note 1, at 31.

[106] As an explanation for the widespread 1985-1986 liability insurance crisis, many commentators pointed to various doctrinal shifts in tort law which expanded liability. The Department of Justice's Tort Policy Working Group touted this theory in its influential 1986 report. The report determined that "tort law appear[ed] to be a major cause of the insurance availability/affordability crisis" of 1985-1986. DOJ REPORT, *supra* note 22, at 80. The report concluded that tort law had undergone disturbing doctrinal changes during the decades prior to the crisis, evidenced by a move towards "no-fault" liability, increasing recognition of joint and several liability, exceptions to the causation requirement based on enterprise and market share theories and reliance on unreliable expert testimony. *Id.* at 30-

the Mississippi Supreme Court defined a physician's duty of care as follows:

> [E]ach physician has a duty to use his or her knowledge and therewith treat through maximum reasonable medical recovery, each patient, with such reasonable diligence, skill, competence, and prudence as are practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment and options.[107]

Recognizing that medical education and training were substantially similar throughout the nation, the court refused to adhere to a local standard of care and, instead, established a national standard of care.[108] Although Mississippi is in the majority of jurisdictions which have rejected a local standard of care, Mississippi's "minimally competent" test creates a lower standard of care than standards of care in other states which require physicians to exercise the skill and knowledge of an "average" or "ordinary" physician.[109] Given that this distinction could very well affect jury consideration, it is arguable that

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35, 80. This theory gained popularity despite the fact that it completely failed to explain why insurers so suddenly and substantially increased premiums in 1985 and 1986 even though these doctrinal changes were gradual and had been evident for years prior to the crisis. Abraham, *supra* note 23, at 405 (stating that, although this unpredictability may have been a partial explanation, there is no obvious explanation for insurers' sudden and precipitous drop in confidence in 1985); Winter, *supra* note 23, at 465 (concluding that the changing risk theory cannot account for suddenness of premium increase). Just as the earlier crisis could not be fully explained by an expansion in tort liability, Mississippi's current medical malpractice liability insurance crisis cannot be attributed to Mississippi's substantive common law governing malpractice cases or to any recent development therein.

[107] Hall v. Hilbun, 466 So. 2d 856, 873 (Miss. 1985).

[108] *Hall*, 466 So. 2d at 869-71.

[109] *Id.* at 870-73; DAN B. DOBBS, THE LAW OF TORTS § 244, at 636-37 (2000); BARRY R. FURROW ET AL., HEALTH LAW § 6-2, at 239 (1995). For states which impose a higher standard, see, for example, *Aiello v. Muhlenberg Regional Medical Center*, 733 A.2d 433, 437 (N.J. 1999) (holding that a doctor must "employ knowledge and skill normally possessed and used by the average physician"); *Bray v. Hill*, 517 N.W.2d 223, 226 (Iowa Ct. App. 1994) ("Doctors are held to such reasonable care and skill as is exercised by the ordinary physician of good standing under like circumstances.").

Mississippi physicians are held to a slightly lower standard of care than physicians in other jurisdictions.[110]

With respect to other issues that arise in medical malpractice cases, Mississippi law is generally consistent with or more conservative than the law applied in most states. Mississippi, along with most other states, recognizes the doctrine of res ipsa loquitor, which essentially relieves the plaintiff from producing expert testimony in certain cases where it may be presumed that the defendant was in fact negligent.[111] A review of recent cases reveals that plaintiffs are rarely successful in their attempts to invoke the doctrine and that when they are it is typically in cases where the defendant has left an object inside the patient during surgery.[112]

Although most courts have relaxed the strict causation requirement in cases involving a lost chance of survival or recovery, Mississippi is among the minority of states which continue to require proof of strict causation in such cases.[113]

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[110] To this extent, physicians enjoy some advantage over other professionals in Mississippi who are required to exercise the skill, knowledge and ability ordinarily possessed and exercised by members of their profession. *See, e.g.*, Wilbourn v. Stennett, Wilkinson & Ward, 687 So. 2d 1205, 1214 (Miss. 1996) (attorney standard); Wirtz v. Switzer, 586 So. 2d 775, 780 (Miss. 1991) (accountant standard).

[111] Brown v. Baptist Mem'l Hosp.-DeSoto, Inc., 806 So. 2d 1131, 1135 (Miss. 2002). In order to invoke the doctrine in Mississippi, the plaintiff must prove: (i) the defendant had exclusive and complete control over the instrumentality causing the damage; (ii) the damage does not ordinarily occur if proper care is used and (iii) the injury was not voluntarily caused by the plaintiff. *Brown*, 806 So. 2d at 1135.

[112] *See, e.g., id.* at 1135 (holding doctrine not applicable in case where child suffered Erb's Palsy); Coleman v. Rice, 706 So. 2d 696, 698 (Miss. 1997) (stating doctrine applicable in case where physician left sponge in patient's body).

[113] Clayton v. Thompson, 475 So. 2d 439, 445 (Miss. 1985) ("Mississippi law does not permit recovery of damages because of mere diminishment of the 'chance of recovery.'"); FURROW ET AL., *supra* note 109, § 6-7, at 262-63 (stating that a minority of jurisdictions reject lost chance theory). *Herskovits v. Group Health Cooperative*, 664 P.2d 474 (Wash. 1983), is the seminal case recognizing a claim for lost chance of recovery. Under current Mississippi law, a plaintiff could not recover damages if the defendant physician's negligence reduced the plaintiff's chance of recovery or survival from fifty percent to one percent because the plaintiff could not prove that but for the defendant's negligence, the plaintiff probably would have recovered or survived. Harris v. Shields, 568 So. 2d 269, 274 (Miss. 1990) (requiring the plaintiff to prove that but for the defendant's negligence, the plaintiff's condition probably would have been substantially improved); Ladner v. Campbell, 515 So. 2d 882, 888-89 (Miss. 1987) (same).

Even though some courts have imposed liability pursuant to the "captain of the ship" doctrine, Mississippi has not yet adopted the doctrine, which authorizes the imposition of vicarious liability upon a physician based on the negligence of others under the physician's control.[114] The Mississippi Supreme Court has, however, held that it is proper to hold a hospital vicariously liable for the negligence of an emergency room physician, radiologist or anesthesiologist in cases where: (i) the patient obtained the services of the hospital without regard to the identity of any particular physician and (ii) the hospital and negligent physician were involved in some type of quasi-contractual relationship.[115] Many other jurisdictions have recently imposed vicarious liability upon hospitals in similar circumstances.[116] Imposition of vicarious liability in these cases is little more than an application of the long established and widely recognized theory of apparent authority.[117]

In lack of informed consent cases, Mississippi law requires a plaintiff to prove that the defendant breached his duty to disclose "known risks which would be material to a prudent patient."[118] Although many states require a physician to disclose only what a reasonable doctor would disclose under similar circumstances, the states are almost evenly divided on this issue.[119] With respect to the manner in which causation must be proved in lack of informed consent cases, Mississippi is in the majority of jurisdictions which require a plaintiff to prove causation based on an objective standard rather than a subjec-

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[114] Starcher v. Byrne, 687 So. 2d 737, 742 (Miss. 1997).

[115] Gatlin v. Methodist Med. Ctr., Inc., 772 So. 2d 1023, 1028-30 (Miss. 2000); Hardy v. Brantley, 471 So. 2d 358, 369-71 (Miss. 1985).

[116] John Dwight Ingram, *Liability of Medical Institutions for the Negligence of Independent Contractors Practicing on Their Premises*, 10 J. CONTEMP. HEALTH L. & POL'Y 221, 223-24 (1994).

[117] *Id.* Even if it could be argued that some jurisdictions would not impose vicarious liability in these circumstances, this is not a new development under Mississippi law given that such liability was first imposed in 1985.

[118] Phillips v. Hull, 516 So. 2d 488, 492-93 (Miss. 1987); Reikes v. Martin, 471 So. 2d 385, 392-93 (Miss. 1985).

[119] DOBBS, *supra* note 109, § 250, at 655 (noting that slightly more than half of the states impose a duty to disclose only what a reasonable doctor would disclose as opposed to what a reasonable patient would want to know).

tive standard.[120] In other words, a plaintiff must prove that a reasonably prudent patient knowing the material risks would not have consented to the treatment; it is insufficient for the plaintiff to simply testify that he or she would not have consented if the defendant physician had adequately disclosed the risks. Even though some jurisdictions have held that a physician may have a duty to disclose his or her own experience and success rate, any drug or alcohol addiction on the part of the physician, and/or the fact that the physician has been diagnosed with a disease such as AIDs, there is no reported Mississippi case specifically recognizing such a duty.[121]

Thus, as this brief survey of Mississippi law indicates, Mississippi substantive common law governing medical malpractice is substantially consistent with or more conservative than the law applied by a majority of jurisdictions. Moreover, there has not been any recent development in Mississippi's substantive common law that might explain the recent crisis.

B. Recent Statutory Reforms and Measures

During a special session in 2002, in response to the medical malpractice crisis and mounting political pressure, the Mississippi Legislature enacted two tort reform bills. The first, House Bill 2, referred to herein as the Medical Malpractice Tort Reform Legislation (MMTRL), focused solely on medical malpractice litigation.[122] The second, House Bill 19, referred to herein as the General Tort Reform Legislation (GTRL), im-

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[120] *Id.* § 250, at 657 (stating that a majority of states use objective standard to prove causation); *see also Phillips*, 516 So. 2d at 493 (Mississippi uses objective standard to prove causation).

[121] DOBBS, *supra* note 109, § 251, at 660-61 (noting that other jurisdictions have recognized these claims).

[122] Act of Oct. 8, 2002, ch. 2, 2003 Miss. Laws 1274 (codified in various Sections of Mississippi Code). During the special session, MACM, the largest malpractice insurer in Mississippi, announced a forty-five percent rate increase, thereby increasing the pressure on the legislature to enact reform. Although MACM officials denied that the timing of the announcement was intended to influence the negotiations taking place during the special session, at least one lawmaker opined that news of the rate hike would probably speed the negotiations. Julie Goodman, *Premiums Rise by 45%: Insurance Group's Hike Comes as Doctors Seek Relief,* CLARION-LEDGER (Jackson, Miss.), Sept. 22, 2002, at A1.

plemented some general reforms applicable to all tort claims, including medical malpractice claims, and other reforms directed at specific types of tort claims such as products liability claims.[123] During the 2003 regular session, the Mississippi Legislature enacted the Medical Malpractice Insurance Availability Act (MMIAA), authorizing the Mississippi Tort Claims Board to sell malpractice insurance.[124] Collectively, these measures greatly reduced health care providers' exposure to liability and also ensured that medical malpractice liability insurance is available to all licensed health care providers in the state.

1. The Medical Malpractice Tort Reform Legislation

The most significant provisions of the MMTRL are the provisions capping noneconomic damages and restricting joint and several liability. Section 7 limits the award of noneconomic damages to $500,000 for claims filed after passage of the MMTRL but before July 1, 2011, to $750,000 for claims filed between July 1, 2011 and June 30, 2017, and to $1,000,000 for claims filed on or after July 1, 2017.[125] Thus, for the next several years, plaintiffs in medical malpractice cases may not recover more than $500,000 for noneconomic damages, even in cases where the plaintiff has sustained permanent injuries which will cause substantial future pain and suffering and preclude a normal life.[126] The MMTRL cap on noneconomic

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[123] Act of Dec. 3, 2002, ch. 4, 2003 Miss. Laws 1289 (codified in various Sections of Mississippi Code).

[124] Act of Apr. 24, 2003, ch. 560, 2003 Miss. Laws 961 (codified at MISS. CODE ANN. § 83-48-5 (Supp. 2003)).

[125] Act of Oct. 8, 2002, ch. 2, § 7, 2003 Miss. Laws 1274 (codified at MISS. CODE ANN. § 11-1-60 (Supp. 2003)). The caps do not apply in cases where the judge determines there is evidence to support a claim for punitive damages. "Noneconomic damages" are defined to include damages for pain and suffering, emotional distress, loss of society and companionship, loss of consortium and loss of enjoyment of life. They do not include damages for disfigurement. Section 13 of the MMTRL provides that the legislation applies only to claims filed after January 1, 2003. Thus, it is unclear whether the $500,000 cap applies to cases filed after passage of the MTTRL but before January 1, 2003.

[126] Although there may be relatively few cases in which the plaintiff has sustained injuries warranting the award of millions of dollars in noneconomic dam-

ages, they do arise. In 2002, the Mississippi Supreme Court affirmed a $9 million jury award against a hospital in a medical malpractice case in which the plaintiff alleged that the hospital's nursing staff negligently caused the plaintiff to suffer permanent disability from brain damage. Brandon HMA, Inc. v. Bradshaw, 809 So. 2d 611, 662 (Miss. 2001). The court held that the jury's award of almost $3 million in noneconomic damages was not excessive. *Bradshaw,* 809 So. 2d at 621-22. The morning after Dawn Bradshaw's admission to the hospital for treatment of bacterial pneumonia, an LPN, who at the time of the incident was working two full-time nursing shifts with the knowledge of his supervisors, gave Bradshaw Ativan, a sedative. Forty minutes later, the same LPN returned and gave her Lorcet Plus, a narcotic, after noticing that Bradshaw's respiration had become short and rapid. No vital signs were taken when either medication was administered. Fifty minutes later, the same LPN returned to check Bradshaw's condition and noted that it had worsened substantially. He left Bradshaw's room to find the floor nurse and by the time they returned, Bradshaw was cyanotic and had stopped breathing. Bradshaw remained in a coma for two weeks. Her MRIs showed brain damage as the result of lack of oxygen. At trial, Bradshaw's expert testified that her brain damage was caused by cardiac arrest which resulted from respiratory arrest. He opined that the nursing staff negligently failed to diagnose and treat Bradshaw's respiratory difficulties. Bradshaw has permanent and severe brain damage. She cannot walk unassisted, is prone to bouts of muscle spasms and cannot perform many basic activities, such as dressing or using the bathroom, without her mother's assistance. *Id.* at 614-17. The court noted that "[s]ince only her motor functions [had] been damaged, the psychological effect [had] also been quite severe." *Id.* at 615. Although three justices dissented concerning other issues, the justices unanimously upheld the hospital's liability as well as the jury's award of noneconomic damages.

In a recent wrongful death case against a physician, the Mississippi Supreme Court affirmed a jury verdict awarding the plaintiffs $1.5 million. Dorrough v. Wilkes, 817 So. 2d 567, 570 (Miss. 2002). There, the husband and son of the thirty-nine-year-old deceased patient, Gwendolyn Wilkes, claimed that she died as the result of the defendant's negligent failure to properly diagnose and treat her sinus tachycardia. The plaintiffs introduced evidence that Mrs. Wilkes incurred $39,000 in medical expenses and that the value of Mrs. Wilkes's lost household services was $300,000. Under the law existing at the time, the jury was permitted to award damages for Mrs. Wilkes's pain and suffering and loss of enjoyment of life, for Mr. Wilkes's loss of society and companionship and for Mrs. Wilkes's son's loss of society and companionship. *Durrough*, 817 So. 2d at 575. In affirming the award, the court found that it was not so excessive as to shock the conscience of the court. *Id.* Clearly, in cases where a patient has experienced permanent disability or death, substantial noneconomic damages may be warranted.

These are the only two recent medical malpractice cases in which the Mississippi Supreme Court has affirmed judgments exceeding $1 million for all damages, economic and noneconomic. Although it has been suggested that the number of million dollar verdicts in Mississippi malpractice cases has skyrocketed in recent years, one recent study determined that the number of Mississippi medical malpractice verdicts exceeding $1 million averaged one per year from 1995 to mid-2002. Vidmar & Brown, *supra* note 25, at 9, 15-20 (concluding that "there is no evidence that Mississippi juries are out of control in medical malpractice cas-

damages establishes an arbitrary limit which applies to all cases. The cap discriminates against plaintiffs who are the most severely injured and plaintiffs who have relatively low noneconomic damages.[127] Moreover, to the extent that the legislation only applies to medical malpractice cases, it grants one class of tortfeasors—health care providers—protection that no other class enjoys.[128] Thus, the $500,000 cap on noneconomic damages is not only a significant limitation on health care providers' exposure to liability, but it is also a substantial and arbitrary limitation on plaintiffs' recovery of actual damages.

Section 4 of the MMTRL greatly restricts the extent to which any single defendant may be held jointly and severally liable. Previously, all defendants in a medical malpractice action could be held jointly and severally liable for the plaintiff's economic and noneconomic damages to the extent necessary for the plaintiff to recover half of his or her recoverable damages.[129] Under the MMTRL, there is no longer any joint and several liability for noneconomic damages. In addition, the only defendants who may be held jointly and severally liable for the plaintiff's economic damages are those who are at least thirty

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es"). Moreover, the parties often settle cases in which million dollar verdicts have been returned for a fraction of the jury award. *Id.* at 16-17. Although such verdicts do influence the settlement value of other cases, the data from the National Practitioner Data Bank indicates that relatively few malpractice payments exceeding $1 million have been made on behalf of Mississippi physicians and that, in the last five years, there has only been one payment exceeding $2 million. *See infra* notes 250-54 and accompanying text. For a discussion of recent medical malpractice cases in which the Mississippi Supreme Court has recently reversed substantial judgments, see *infra* notes 185-94 and accompanying text.

[127] The cap discriminates against the most severely injured plaintiffs because they are the plaintiffs who will not fully recover their noneconomic damages. Plaintiffs who sustain minimal noneconomic damages will be fully compensated. In addition, plaintiffs who sustain noneconomic damages exceeding the cap and relatively minimal economic damages will recover a lower percentage of their total compensatory damages than plaintiffs who sustain substantial economic damages but relatively low noneconomic damages. Thus, the cap discriminates not only against the most severely injured, but also, to some extent, against plaintiffs who are low wage earners.

[128] For this reason, some courts have found that caps limited to medical malpractice cases violate their state's equal protection clause. For a general discussion of some of these cases, see Appendix C.

[129] MISS. CODE ANN. § 85-5-7 (2001) (now amended).

percent at fault. Even then, such defendants can only be held jointly and severally liable to the extent necessary for the plaintiff to recover fifty percent of his or her recoverable economic damages.[130] The liability scheme implemented by the MMTRL is more favorable to defendants than any of the hybrid or compromise liability schemes described in the *Restatement (Third) of Torts*, in that it places substantially more of the risk that any tortfeasor is insolvent or immune on the plaintiff rather than on the defendant(s).[131]

In addition to caps on noneconomic damages and severe limitations on joint and several liability, the MMTRL contains several other provisions which provide additional protection to defendants or place additional burdens on plaintiffs in medical malpractice lawsuits. Section 6 provides that in any malpractice case in which expert testimony will be required, the plaintiff's attorney must attach an affidavit to the complaint

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[130] Act of Oct. 8, 2002, ch. 2, § 4 (codified at MISS. CODE ANN. § 85-5-7 (Supp. 2003)). The MMTRL provides that fault may be allocated to all tortfeasors, including non-parties and immune parties.

[131] A liability scheme which imposes joint and several liability on defendants places all of the risk that any single tortfeasor may be immune or insolvent on the defendants. A liability scheme which imposes pure several liability on defendants places all of the risk that any single tortfeasor may be immune or insolvent on the plaintiff. Although many states have enacted some type of hybrid liability scheme in an effort to reach a compromise between these two extremes, the liability scheme implemented by the MMTRL substantially favors defendants because it imposes joint and several liability in very narrow circumstances—only when a defendant is thirty to fifty percent at fault and only for half of the plaintiff's recoverable economic damages. The three hybrid schemes described in the *Restatement (Third) of Torts* are schemes which, when compared to the MMTRL, more evenly distribute the risk that a tortfeasor will be immune or insolvent. Under Track C of the Restatement, joint and several liability is imposed on the defendants, but an insolvent defendant's fault may be reallocated to all other responsible parties, including the plaintiff, according to their proportionate share of the fault. Under Track D of the Restatement, joint and several liability may be imposed only on those defendants whose fault exceeds a threshold percent, such as thirty percent. Under Track E of the Restatement, joint and several liability may be imposed on all defendants, but only for economic damages. RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY §§ C18, C21, D18, E18 (2000). Compared to plaintiffs entitled to recover under these hybrid liability schemes, a Mississippi plaintiff bears a much greater portion of the risk that any tortfeasor is insolvent or immune. A good argument can be made that a negligent defendant, rather than an innocent patient, should bear all or most of the risk.

certifying that the attorney: (a) has consulted with an expert qualified to testify as to the standard of care and that based on such consultation, the attorney has concluded that there is a reasonable basis upon which to commence the case; (b) was unable to obtain such consultation prior to the expiration of the statute of limitations (in which case, the attorney shall obtain and certify such consultation within sixty days of filing the complaint); or (c) was unable, after three good faith attempts, to obtain such consultation.[132]

Section 2 revised the definition of "employee" for purposes of the Mississippi Tort Claims Act (MTCA) to specifically include a physician "employed by the University of Mississippi Medical Center (UMMC) and its departmental practice plans who is a faculty member and provides health care services only for patients at UMMC or its affiliated practice sites."[133] Pursuant to the MTCA, "employees" are immune from tort claims arising from acts or omissions occurring within the course and scope of their duties.[134] This revised definition is consistent with recent opinions rendered by the Mississippi Supreme Court and will likely decrease the number of cases in which a disputed fact issue exists concerning whether a physician is an "employee" for purposes of the MTCA.[135]

Section 3 imposes a heightened pleading requirement on plaintiffs seeking damages arising from the ingestion of a prescription drug approved by the Food and Drug Administra-

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[132] Act of Oct. 8, 2002, ch. 2, § 6 (codified at MISS. CODE ANN. § 11-1-58 (Supp. 2003)). The requirement does not apply to plaintiffs proceeding pro se. Nor does it apply to claims alleging lack of informed consent or claims based on res ipsa loquitor.

[133] *Id.* § 2 (codified at MISS. CODE ANN. § 11-46-1(f) (Supp. 2003)).

[134] MISS. CODE ANN. § 11-46-7(2) (2002).

[135] In a recent line of cases, the Mississippi Supreme Court repeatedly addressed the issue of whether physicians employed at UMMC were "employees." *See, e.g.*, Watts v. Tsang, 828 So. 2d 785 (Miss. 2002); Conley v. Warren, 797 So. 2d 881 (2001); Sullivan v. Washington, 768 So. 2d 881 (2000); Smith v. Braden, 765 So. 2d 546 (Miss. 2000); Miller v. Meeks, 762 So. 2d 302 (2000). The revised definition of "employee" is consistent with the results reached by the court in recent cases such as *Watts*, where the court held that a faculty physician who received income from a departmental practice plan was an "employee" because the physician was acting within the scope of his employment and worked only at UMMC and its affiliated sites. *Watts*, 828 So. 2d at 798-99.

tion.[136] It requires a plaintiff suing a physician for damages caused by such a prescription drug to plead "specific facts which, if proven, amount to negligence on the part of the medical provider."[137] Previously, all that was required of plaintiffs in such cases was "notice" pleading.[138] Section 5 shortened the statute of limitations in medical malpractice actions against nursing homes from three years to two and requires sixty days' written notice to defendants in all medical malpractice cases.[139]

Thus, contrary to assertions that the MMTRL contained no meaningful tort reform, the MMTRL substantially limited health care providers' exposure to liability and also placed additional burdens on plaintiffs filing medical malpractice cases.[140] John Cook, the President of the Mississippi State Medical Association, lauded the legislature for passing the statute and estimated that it would take a minimum of two years for the legislation to stabilize rates.[141] Charmaine Kanosky, the

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[136] Act of Oct. 8, 2002, ch. 2, § 3 (codified at MISS. CODE ANN. § 11-1-62 (Supp. 2003)).

[137] *Id.* The Legislature intended to "immunize innocent medical providers ... who are not actively negligent from forum-driven lawsuits." *Id.* Presumably, a physician who prescribes an FDA-approved drug actively breaches the applicable standard of care if a minimally competent physician would not have prescribed the drug under similar circumstances or if the physician failed to give a warning about the associated risks, which warning would have been given by a minimally competent physician under similar circumstances.

[138] MISS. R. CIV. P. 8.

[139] Act of Oct. 8, 2002, ch. 2, § 5 (codified at MISS. CODE ANN. §§ 15-1-36(2), (15) (2003)).

[140] The MMTRL also contained other relatively minor provisions. Section 8 directed the Commissioner of Insurance to conduct a study concerning the number of physicians unable to obtain insurance. For a discussion of some results of the survey, see *supra* notes 9-10. Sections 9 and 10 define medical records of institutions for the aged and infirm and provide that such records remain the property of such institutions, subject to reasonable access by residents or their representatives. Section 11 grants immunity under certain circumstances to physicians and others rendering health care services voluntarily and without expectation of payment. Act of Oct. 8, 2002, ch. 2, §§ 8-11 (§§ 9 and 10 are codified at MISS. CODE ANN. §§ 43-11-1 and 43-11-16 (Supp. 2003) and § 11 is codified at MISS. CODE ANN. §11-1-71 (Supp. 2003)). Although Section 1 of the MMTRL revised MISS. CODE ANN. § 11-11-3 to require that medical malpractice cases be brought in the county where the alleged act or omission occurred, this requirement was removed by the GTRL. *Id.* § 1 (repealed by the GTRL as discussed *infra* notes 150-53 and accompanying text).

[141] Patrice Sawyer, *Governor Signs Medical Tort Reform Bill*, CLARION-LEDGER

deputy director of government affairs for the Mississippi State Medical Association, acknowledged that the legislation "would go a long way toward improving the [legal] climate."[142]

2. The General Tort Reform Legislation

The GTRL, which was enacted shortly after the MMTRL, contains several general provisions which apply to medical malpractice cases. Section 10(1) provides that, although damages for pain and suffering and for loss of enjoyment of life may be recovered in civil actions, "there shall be no recovery for loss of enjoyment of life as a separate element of damages apart from pain and suffering damages, and there shall be no instruction given to the jury which separates loss of enjoyment of life from pain and suffering."[143] Thus, although a plaintiff may still present evidence of loss of enjoyment of life damages for jury consideration, the jury will not be instructed that such damages are separate and distinct from damages for pain and suffering.

Section 10(1) also prohibits expert testimony on the issue of hedonic damages.[144] Previously, the Mississippi Supreme Court had authorized the admission of such testimony.[145] Section 10(2) prohibits the award of damages for "loss of enjoyment of life caused by death."[146] This is a substantial departure from previous practice pursuant to which trial courts instructed juries in wrongful death cases to consider the

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(Jackson, Miss.), Oct. 9, 2002, at A1; Patrice Sawyer & Julie Goodman, *Pain, Suffering Awards Capped*, CLARION-LEDGER (Jackson, Miss.), Oct. 8, 2002, at A1; *see also*, *Houpt Reminisces Over 25 Years at MACM*, THE MACM MONITOR, Jan. 2004, at 6, *available at* http://www.macm.net/pdf/monq104.pdf (last visited April 10, 2004) [hereinafter *Houpt Reminisces*] (stating that the tort reform measures "will ultimately improve the legal climate").

[142] *Slow Improvement Seen in Mississippi Medical-Liability Climate*, BEST'S INS. NEWS, May 2, 2003, *available at* 2003 WL 4280839 [hereinafter *Slow Improvement*].

[143] Act of Dec. 3, 2002, ch. 4, § 10(1), 2003 Miss. Laws 1289 (codified at MISS. CODE ANN. § 11-1-69(1) (Supp. 2003)).

[144] *Id.*

[145] Kansas City So. Ry. v. Johnson, 798 So. 2d 374, 381-82 (Miss. 2001).

[146] Act of Dec. 3, 2002, ch. 4, § 10(2) (now codified at MISS. CODE ANN. § 11-1-69(2) (Supp. 2003)).

decedent's loss of enjoyment of life as a separate element of damages, even in cases where the decedent's death was instantaneous.[147]

Section 14 of the GTRL repealed statutory provisions that had previously required the Mississippi Supreme Court to impose a fifteen percent penalty on defendants who appealed a judgment and then lost the appeal.[148]

Section 6 limited punitive damages in all civil actions. The limit varies depending on the defendant's net worth. For example, the cap is $5 million for a defendant with a net worth of more than $50 million but less than $100 million. As the defendant's net worth increases, so does the cap. If a defendant's net worth exceeds $1 billion, $20 million is the most that can be awarded as punitive damages. If a defendant's net worth is $50 million or less, the cap is four percent of the defendant's net worth.[149] The cap on punitive damages will reduce health care provider liability in those very rare medical malpractice cases where it might be appropriate to impose punitive damages.

Prior to the MMTRL and the GTRL, venue for a medical malpractice action was appropriate in the:

> county in which the defendant or any of them may be found or in the county where the cause of action may occur or accrue and, if the defendant is a domestic corporation, in the county in which said corporation is domiciled or in the county where the cause of action may occur or accrue . . . .[150]

Thus, under the old venue provisions, a plaintiff could sue a physician in the county where the physician resided, in the county where the alleged negligence occurred or in the county

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[147] *See, e.g.*, Choctaw Maid Farms, Inc. v. Hailey, 822 So. 2d 911, 922-23 (Miss. 2003).

[148] Act of Dec. 3, 2002, ch. 4, § 14 (repealing MISS. CODE ANN. § 11-3-23 and § 11-3-25).

[149] *Id.* § 6 (codified at MISS. CODE ANN. § 11-1-65(3) (Supp. 2003)). The limits do not apply if the defendant was under the influence of alcohol or illegal drugs at the time of the incident or if the defendant is convicted of a felony which caused the damages. MISS. CODE ANN. § 11-1-65(3)(d) (Supp. 2003).

[150] Act of Apr. 23, 1984, ch. 429, 1984 Miss. Laws 208 (codified at MISS. CODE ANN. § 11-11-3 (1999) (amended in 2002 and 2004)).

where the injury or damage was first sustained.[151] Section 1 of the GTRL provides that in civil actions brought against a resident defendant, the claim "shall be commenced in the county where the defendant resides or in the county where the alleged act or omission occurred or where the event that caused the injury occurred."[152] Thus, in medical malpractice cases where the defendant's negligence does not cause any immediate injury or damage, it appears that venue may no longer be appropriate in the county in which the injury or damage is first sustained.[153] To this extent, the GTRL limits venue possibilities in medical malpractice actions.

In addition, the GTRL limits the extent to which attorneys not admitted to practice in Mississippi can advertise or solicit clients, authorizes the imposition of an additional fine when a court finds that a party has filed a frivolous pleading and provides that state trial judges should not be assigned to cases until a defendant has filed a responsive pleading.[154] Thus, in

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[151] The Mississippi Supreme Court interpreted where the defendant "may be found" to mean the county where the defendant resides. *See, e.g.*, Stubbs v. Miss. Farm Bureau Cas. Ins. Co., 825 So. 2d 8, 14 (2002). The court narrowly interpreted "where the cause of action may occur or accrue" to include only the county in which the plaintiff's initial damages or injuries were sustained, even though the plaintiff continued to sustain additional injuries in a different county. Forrest County Gen. Hosp. v. Conway, 700 So. 2d 324, 326-27 (Miss. 1997).

[152] Act of Dec. 3, 2002, ch. 4, § 1 (codified at MISS. CODE ANN. § 11-11-3 (Supp. 2003)). This section removed the venue provision dealing specifically with medical malpractice claims that had been enacted by the MMTRL.

[153] In wrongful death cases, venue was appropriate under the old statute in the county in which the patient died. McMillan v. Puckett, 678 So. 2d 652, 655-56 (Miss. 1996) (holding that wrongful death action does not accrue until death). Under House Bill 19, it appears that venue continues to be appropriate in the county where the patient dies, given that "death" is the event which caused the injury for which recovery is sought.

[154] The GTRL also enacted provisions which dealt specifically with claims based on products liability, premises liability and the liability of gun or ammunition manufacturers. The GTRL also limited joint and several liability in all civil actions in the same manner as the MMTRL limited joint and several liability in medical malpractice cases. Act of Dec. 3, 2002, ch. 4, §§ 3, 4, 5, 7, 9 (§ 3 dealing with joint and several liability is codified at MISS. CODE ANN. § 85-5-7 (Supp. 2003); §§ 4 and 5 dealing with products liability claims are codified at MISS. CODE ANN. §§ 11-1-63 and 11-1-64 (Supp. 2003); § 7 dealing with premises liability is codified at MISS. CODE ANN. § 11-1-66 (Supp. 2003); § 9 dealing with liability of gun and ammunition manufacturers is codified at MISS. CODE ANN. § 11-1-

addition to the tort reform measures enacted as part of the MMTRL, the GTRL implemented reforms which further restricted health care providers' exposure to liability for medical malpractice.[155]

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67 (Supp. 2003)).

[155] In response to previous perceived liability insurance crises and other calls for tort reform legislation, the Mississippi Legislature enacted a variety of statutory reforms which limited, rather than expanded, health care providers' exposure to liability. In 1976, a separate two-year statute of limitations was created for medical malpractice actions. Act of May 25, 1976, ch. 473, § 1, 1976 Miss. Laws 784 (codified as amended at MISS. CODE ANN. § 15-1-36 (2003)). The two-year period for medical malpractice actions does not begin to run until "the date the alleged act, omission or neglect shall or with reasonable diligence might have been first known or discovered." *Id.* Previously, medical malpractice actions had been governed by MISS. CODE ANN. § 15-1-49, which, in 1976, provided for a six-year limitations period. Currently the two-year limitations period for medical malpractice claims is shorter than the three-year limitations period which applies to most other negligence claims. MISS. CODE ANN. § 15-1-49 (2003).

In 1983, the Legislature passed a statute prohibiting plaintiffs in medical malpractice cases from seeking a specific amount of damages in the complaint. Act of Mar. 29, 1983, ch. 425, § 1, 1983 Miss. Laws 302 (codified at MISS. CODE ANN. § 11-1-59 (Supp. 2003)). Many states enacted similar legislation to eliminate ad damnum clauses because it was believed that some plaintiffs sought exaggerated and sensational amounts of damages. Alice M. Noble-Allgire, *Removal of Diversity Actions When the Amount in Controversy Cannot Be Determined from the Face of Plaintiff's Complaint: The Need for Judicial and Statutory Reform to Preserve Defendant's Equal Access to Federal Courts*, 62 MO. L. REV. 681, 689-90 & nn.12-15 (1997).

In 1989, the Legislature limited joint and several liability. Prior to the 1989 statute, joint and several liability had been imposed upon negligent joint tortfeasors, thereby making each defendant jointly and severally liable for the entire amount of the plaintiff's damages. The 1989 legislation established several liability as the norm and provided that joint and several liability could only be imposed upon a defendant to the "extent necessary for the [plaintiff] to recover fifty percent (50%) of his recoverable damages." Act of Mar. 2, 1989, ch. 311, § 1, 1989 Miss. Laws 19 (codified as amended at MISS. CODE ANN. § 85-5-7 (1999)).

In 1990, legislation was passed requiring experts in malpractice actions against physicians to be licensed as a doctor of medicine in Mississippi or some other state. Act of Mar. 21, 1990, ch. 440, § 1, 1990 Miss. Laws 292 (codified at MISS. CODE ANN. § 11-1-61 (2002)). Apparently, the Mississippi Medical Association lobbied for legislation that would have established a local or community standard of care for physicians and prohibited expert testimony unless the expert was in the same specialty as the defendant. David L. Meredith, Comment, *The Medical Expert Witness in Mississippi: Outgunning the Opposition*, 64 MISS. L. J. 85, 90-92 (1994). The resulting legislation was much weaker, requiring only that an expert be licensed as a doctor of medicine.

In 1993, the Legislature enacted a statute restraining the award of punitive damages, which legislation applies to medical malpractice cases. Act of Feb. 18,

3. The Medical Malpractice Insurance Availability Act

During the 2003 regular session, the Mississippi Legislature passed the Medical Malpractice Insurance Availability Act (MMIAA).[156] The MMIAA created the Medical Malpractice Insurance Availability Plan to provide medical malpractice liability insurance to health care providers licensed in Mississippi, including hospitals, physicians, nurses and institutions for the aged and infirm.[157] The MMIAA provides that the plan "shall" provide coverage to all such entities or individuals in an amount not to exceed $1 million per occurrence and $3 million in the aggregate per year.[158] The MMIAA also requires the plan to make "tail" coverage available.[159] Rates charged are to be actuarially sound and self-supporting.[160] Although the plan

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1993, ch. 302, § 2, 1993 Miss. Laws 4 (codified as amended at MISS. CODE ANN. § 11-1-65 (2002)). The statute heightened the plaintiff's burden of proof to "clear and convincing evidence" and limited the award of punitive damages to cases where the defendant "acted with actual malice, gross negligence which evidences a willful, wanton or reckless disregard for the safety of others, or committed actual fraud." *Id.* The statute further requires the trial court to bifurcate the trial and to submit the issue of punitive damages to the jury only if the jury awards actual damages and only if the plaintiff meets the requisite evidentiary burden. The jury is to be instructed that "the primary purpose of punitive damages is to punish the wrongdoer and deter similar misconduct in the future by the defendant and others." The jury is to consider the "defendant's financial condition and net worth; the nature and reprehensibility of the defendant's wrongdoing . . .; the defendant's awareness of the amount of harm being caused and the defendant's motivation in causing such harm; the duration of the defendant's misconduct and whether the defendant attempted to conceal such misconduct," and any other relevant factors. Prior to entering an award for punitive damages, the court is to make a determination whether the damages are excessive, considering many of the same factors as well as any criminal penalties that may have been imposed on the defendant.

In 1998, legislation was passed imposing a seven-year statute of repose in medical malpractice cases. Act of Apr. 17, 1998, ch. 573, § 1, 1998 Miss. Laws 922 (codified at MISS. CODE ANN. § 15-1-36 (2003)). The provision bars any medical malpractice case more than seven years after the alleged negligence, even if such negligence could not have been reasonably discovered within the seven-year period.

[156] Act of Apr. 24, 2003, ch. 560, 2003 Miss. Laws 961 (codified at MISS. CODE ANN. § 83-48-5 (Supp. 2003)).

[157] MISS. CODE ANN. § 83-48-5(2)(a) (Supp. 2003).

[158] *Id.* §§ 83-48-5(2)(a), (b)(i).

[159] *Id.* § 83-48-5(2)(a).

[160] *Id.* § 83-48-5(5). Insureds must agree to provide services to Medicaid recipi-

has a repeal date of July 1, 2005, it has provided relief to physicians who previously were unable to obtain coverage.[161]

C. Recent Judicial Reforms

In addition to the reforms enacted by these statutory measures, the Mississippi Supreme Court has recently amended various evidentiary and procedural rules and has also rendered several significant opinions which depart from earlier precedent and practice.

1. *McLemore* and Mississippi Rule of Evidence 702

In *Mississippi Transportation Commission v. McLemore*, the Mississippi Supreme Court replaced its *Frye* test governing the admissibility of expert testimony with the *Daubert* test.[162] Under the *Daubert* test, the trial court must first determine whether the expert testimony is relevant. Then, it must determine whether the expert testimony is reliable, considering various factors such as whether the expert's theory has been tested or subjected to peer review, whether there is a known rate of error and whether the theory has been generally accepted.[163] Recent studies suggest that trial courts applying *Daubert* are more likely to scrutinize and exclude expert testimony, thereby increasing summary judgments in favor of defendants.[164] In adopting *Daubert*, the court acknowledged that

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ents, State and School Employees Health Insurance Plan participants and Children's Health Insurance Program participants. *Id.* § 83-48-5(6)(a).

[161] Lynne W. Jeter, *Reform Remains Big Issue in Malpractice Insurance Market*, 25 MISS. BUS. J., Dec. 1, 2003, at 14. Towards the end of 2003, 124 physicians had purchased coverage pursuant to the MMIAA. Lynne W. Jeter, *Housekeeping Items, More Tort Reform Expected in Session*, 25 MISS. BUS. J., Dec. 1, 2003, at 18.

[162] Miss. Transp. Comm'n v. McLemore, 863 So. 2d 31, 39-40 (2003) (adopting the standard governing the admissibility of expert testimony established in Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993)).

[163] *McLemore*, 863 So. 2d at 37-38.

[164] The two studies, the Rand Study and the 2000 Federal Judicial Center Study, indicate that after *Daubert*, federal judges were much more likely to carefully scrutinize the admission of expert testimony. According to the Rand Study, this increased scrutiny led to more frequent exclusion of expert testimony and more frequent granting of summary judgments. Sofia Adrogue & Alan Ratliff, *The Independent Expert Evolution: From the "Path of Least Resistance" to the "Road*

"the *Daubert* test has effectively tightened, not loosened, the allowance of expert testimony."[165] The court, just months earlier, had amended Mississippi Rule of Evidence 702, governing the admission of expert testimony, to conform to Federal Rule of Evidence 702.[166] Thus, to the extent that tort reform advocates have complained that medical malpractice judgments for the plaintiff have been based on unreliable expert testimony or "junk science," those concerns have been squarely addressed by the court's amendment of Mississippi Rule of Evidence 702 and its adoption of the *Daubert* test.[167]

2. *Janssen* and Mississippi Rules of Civil Procedure 20, 42 and 82

In *Janssen*, a case likely to have a substantial impact on the medical malpractice liability insurance market, the Mississippi Supreme Court held that it was improper for fifty-six plaintiffs to use Mississippi Rule of Civil Procedure 20(a) to join medical malpractice claims against forty-two physicians in a case brought in Jones County in which the plaintiffs alleged that they sustained damage as the result of the physicians' negligent prescription of the drug Propulsid.[168] The plaintiffs

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Less Traveled?", 34 TEX. TECH. L. REV. 843, 847 (2003); MOLLY TREADWAY JOHNSON ET AL., FEDERAL JUDICIAL CENTER, EXPERT TESTIMONY IN FEDERAL CIVIL TRIALS: A PRELIMINARY ANALYSIS (2000), *available at* http://www.fjc.gov/newweb/jnetweb.nsf/autoframe?openform&url_r=pages/333 (last visited Apr. 10, 2004). Some commentators have argued that many trial judges applying *Daubert* misunderstand and misapply the factors in a manner which excludes reliable testimony. *See, e.g.*, Joelle Anne Moreno, *Eyes Wide Shut: Hidden Problems and Future Consequences of the Fact-Based Validity Standard*, 34 SETON HALL L. REV. 89 (2003); PROJECT ON SCIENTIFIC KNOWLEDGE AND PUBLIC POLICY, TELLUS INSTITUTE, DAUBERT: THE MOST INFLUENTIAL SUPREME COURT RULING YOU'VE NEVER HEARD OF (June 2003), *available at* http://www.defendingscience.org/pdf/DaubertReport.pdf (last visited Apr. 20, 2004).

[165] *McLemore*, 863 So. 2d at 38.

[166] *Id.* at 35. Mississippi Rule of Evidence 702 authorizes the admission of expert testimony only when it is based upon "sufficient facts or data" and is the "product of reliable principles and methods" and only when the expert has reliably applied the principles and methods to the facts of the case.

[167] Several of the physicians responding to the Mississippi Department of Insurance survey complained about unqualified expert testimony. *See supra* note 9, at Exhibit 3 (Questionnaire Comments).

[168] Janssen Pharmaceutica, Inc. v. Armond, 866 So. 2d 1092, 1095 (Miss. 2004).

also sued the drug manufacturer and its parent company on various products liability and negligence claims.

Mississippi Rule of Civil Procedure 20(a), which governs permissive joinder of multiple claims in a single case, is patterned after Federal Rule of Civil Procedure 20(a) and requires that the claims to be joined arise out of the same transaction, occurrence or series of transactions or occurrences and that the claims involve a common question of law or fact. In *American Bankers Insurance v. Alexander*, a 2001 case governed by Mississippi Rule of Civil Procedure 20(a), the court, noting that Mississippi lacks a class action rule, indicated that it was appropriate to liberally interpret procedural rules in an effort to accommodate parties who might otherwise have no access to the legal system.[169] In *American Bankers*, the court approved joinder of 1371 individual plaintiffs' claims against a lender and a collateral protection insurer in a case in which each of the plaintiffs alleged that the defendants were engaged in a fraudulent scheme whereby the lender force placed the insurer's policies on the plaintiffs at rates substantially higher than market rates.[170] Since joinder was proper in *American Bankers*, all 1371 plaintiffs were able to establish venue for their claims in Jefferson County, Mississippi, because Mississippi Rule of Civil Procedure 82 provides that joined claims may be brought in any county in which any one of the claims could have been brought. In arguing that joinder was improper, the defendants in *American Bankers* were attempting to avoid litigating the claims in Jefferson County, one of the Mississippi counties perceived to be favorable to plaintiffs.[171]

The court's decision in *American Bankers* encouraged the filing of many mass tort cases, such as *Janssen,* in counties perceived to be favorable to plaintiffs.[172] In *Janssen*, however,

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[169] Am. Bankers Ins. v. Alexander, 818 So. 2d 1073, 1078 (Miss. 2001).

[170] *Am. Bankers,* 818 So. 2d at 1075.

[171] *Id.* at 1080 ("The overriding theme of American Bankers is its disagreement with venue of the instant action in Jefferson County."). Claiborne, Copiah, Hinds, Holmes and Jefferson Counties are among the counties which are perceived by some as being favorable to plaintiffs. Jimmie E. Gates, *Stats Erode State's "Jackpot Justice" Image*, CLARION-LEDGER (Jackson, Miss.), Mar. 8, 2004, at A1.

[172] *Message from the President*, THE MACM MONITOR, Sept. 2003, at 1, *avail-*

the court distinguished *American Bankers*, noting that each of the plaintiffs in that case brought essentially the same claim against the defendants, with the only difference being the amount of premiums each was overcharged.[173] Addressing the multiple claims in *Janssen*, the court held that joinder of the fifty-six medical malpractice claims against the forty-two physicians in one case was improper because the "prescribing of the drug Propulsid by 42 different physicians to 56 different patients did not arise out of the same transaction, occurrence, or series of transactions or occurrences."[174] The court was reasonably concerned that trying all of these claims in a single trial might overwhelm a jury, given that the jury would be charged with examining, among other things, each patient's medical history, any warnings that were given to each patient, whether ingestion of the drug caused each patient damages and, if so, to what extent.[175] Refusing to acknowledge, however, that joinder during the discovery phase might result in substantial cost savings for the parties and the trial court, the court remanded the case to the trial court and ordered the trial court to sever and transfer all claims against physicians other than the physician who prescribed the drug to the sole plaintiff residing in Jones County.[176]

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able at http://www.macm.net/pdf/monq303.pdf (last visited Apr. 10, 2004) (stating that a large majority of claims reported to MACM in late 2002 and early 2003 were claims in mass tort cases). *See infra* notes 230-36 and 304-10 and accompanying text for a more detailed discussion of data concerning the number of such mass tort cases involving claims against Mississippi physicians. Although some plaintiffs may have named Mississippi physicians as defendants to prevent removal of the cases to federal court or to establish venue in a certain county, plaintiffs cannot file such claims without believing "there is good ground to support [them]." MISS. R. CIV. P. 11. Moreover, in many instances plaintiffs must consider bringing claims against the prescribing physicians because the drug manufacturer may rely on the learned intermediary doctrine, codified at MISS. CODE ANN. § 11-1-63(c)(ii) (Supp. 2003), pursuant to which a drug manufacturer can escape liability for failing to warn a patient about the risks posed by a drug if the manufacturer provided the physician with the necessary information concerning the risks.

[173] *Janssen*, 866 So. 2d at 1097-98.

[174] *Id.* at 1095.

[175] *Id.* at 1098.

[176] *Id.* at 1102. The court ordered the trial court to transfer these claims because venue was no longer appropriate in Jones County pursuant to Mississippi Rule of Civil Procedure 82, given that the claims were not properly joined. In a

Prior to the court's decision in *Janssen*, a major concern expressed by physicians and their insurers was potential mass tort litigation in venues perceived to be very favorable to plaintiffs.[177] The court's *Janssen* decision drastically reduced plaintiffs' ability to use mass joinder of medical malpractice claims as a means of suing physicians in counties where venue would otherwise be inappropriate.[178]

The day after the Mississippi Supreme Court decided *Janssen*, it issued an order revising the Comments to Mississippi Rule of Civil Procedure 20 to clarify that the "phrase 'transaction or occurrence' requires that there be a distinct litigable event linking the parties."[179] The court further revised the Comments to direct trial courts to consider, in cases where the criteria for joinder have been met, whether "different injuries, different damages, different defensive postures and other individualized factors will be so dissimilar as to make management of cases consolidated under Rule 20 impractical."[180] In the same order, the court revised the Comment to Rule 42 to indicate that cases should be consolidated only "where the issues of law or fact justifying consolidation predominate over individual issues which will be heard in the

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separate Propulsid case that was also brought against Janssen, the Mississippi Supreme Court held that joinder of ten plaintiffs' suits against Janssen was improper even though the plaintiffs had not sued multiple physicians and were only pursuing claims against Janssen and its parent company. Janssen Pharmaceutica Inc. v. Bailey, 878 So. 2d 31 (Miss. 2004). The court reversed the $48 million judgment and remanded the case for severance and separate trials in appropriate venues. *Id.*

[177] *See, e.g.,* MDI REPORT, *supra* note 9, at Exhibit 3 (Questionnaire Comments); *Message from the President*, *supra* note 9, at 1.

[178] For a discussion of the venue provisions as amended by the GTRL, see *supra* notes 150-53 and accompanying text.

[179] Mississippi Supreme Court Order, *In re* The Mississippi Rules of Civil Procedure, No. 89-R-99001-SCT (Feb. 20, 2004), *available at* http://www.mssc.state.ms.us/news/sn111468.pdf (last visited April 9, 2004) [hereinafter Order]. There is no such requirement in the Comments to Federal Rule of Civil Procedure 20. The requirement of a "distinct litigable event" arguably goes much too far in reigning in joinder. Rather than requiring a distinct litigable event, many federal courts merely require that there be a logical relationship between the events giving rise to the claims to be joined. *See, e.g.,* Mosley v. Gen. Motors Corp., 497 F.2d 1330, 1333 (8th Cir. 1974).

[180] Order, *supra* note 179.

consolidated proceedings."[181] Finally, the court revised Mississippi Rule of Civil Procedure 82 to include a provision authorizing trial courts to transfer cases to other jurisdictions within Mississippi based on the doctrine of forum non conveniens.[182] Previously, the court had refused to recognize intrastate forum non conveniens.[183] Despite suggestions that the court should adopt a class action rule to accommodate cases where mass joinder is appropriate, it failed to do so.[184]

The court's decision in *Janssen*, as well as the court's amendment of the procedural rules, should immediately and significantly decrease the number of claims brought against physicians in mass tort cases involving prescription drugs. Although plaintiffs may individually bring medical malpractice claims against physicians based on their negligent prescription of drugs, it is likely that the total number of such claims will substantially decrease because the cost of individually prosecuting such claims is much greater. In addition, *Janssen* severely limits the use of mass joinder of malpractice claims as a method of establishing venue in favorable forums.

3. Recent Cases Indicating the Court is Closely Scrutinizing Medical Malpractice Cases and High Damage Awards

The Mississippi Supreme Court, in several recent cases, has indicated that, in today's political climate, it is closely reviewing medical malpractice awards as well as high damage awards in other types of tort cases. Most notably, in *Eckman v. Moore*, a wrongful death case, the court withdrew its original

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[181] *Id.* This requirement imposes an unnecessarily high burden on parties seeking to consolidate cases arising out of the same transaction or occurrence and will foreclose consolidation in instances where consolidation could result in substantial economic benefit for the court as well as the parties. Such a requirement is more appropriate for class action litigation as evidenced by the federal rule requiring, in certain types of class actions, that the common issues of law and fact predominate over issues affecting individual members of the class. FED. R. CIV. P. 23(b)(3). No such requirement for consolidation exists under Federal Rule of Civil Procedure 42.

[182] Order, *supra* note 179.

[183] *See, e.g.*, Clark v. Luvel Dairy Prods., Inc., 731 So. 2d 1098 (Miss. 1998).

[184] Janssen Pharmaceutica, Inc. v. Armond, 866 So. 2d 1092, 1102 (Miss. 2004) (Graves, J., concurring) (arguing that the court should adopt a class action rule).

opinion affirming the jury's $3 million verdict against the defendant doctor and issued an opinion on rehearing which reversed the judgment and ordered a new trial.[185] The case, which was filed in 2000, received national attention after the jury rendered a $5 million verdict in favor of the plaintiffs against Dr. Eckman, a neurosurgeon, and North Mississippi Medical Center (NMMC).[186] The jury allocated sixty percent of the fault to Eckman and forty percent to NNMC and the trial court entered judgment accordingly.[187]

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[185] Eckman v. Moore, 876 So. 2d 975 (Miss. 2004) [hereinafter *Eckman II*] (opinion on rehearing); Eckman v. Moore, No. 2002-CA-00669-SCT, 2003 WL 22411078 (Miss. Oct. 23, 2003) [hereinafter *Eckman I*] (original opinion).

[186] Michael Freedman, *The Tort Mess*, FORBES, May 13, 2002; Michaela Gibson Morris, *Court Overturns Verdict Against Doctor*, NORTHEAST MISS. DAILY J. (Tupelo, Miss.), Mar. 27, 2004, at A1 (noting that the case landed Eckman on the front cover of the May 13, 2002 Forbes magazine).

[187] The facts, culled from both of the court's *Eckman* opinions cited *supra* at note 185, indicate that on the evening of February 20, 1999, Taylor Moore sought treatment at NMMC after falling and hitting his head on the floor of a movie theater. The scans ordered by the emergency room physician indicated bleeding in the frontal lobe. Eckman first examined Moore on the morning of February 21, 1999 and did not detect any abnormalities. Early that afternoon, Moore began to complain of nausea and worsening headaches. When notified by phone of these complaints, Eckman did not go to examine Moore, but instead ordered medication. The plaintiffs' expert testified that Eckman breached the standard of care by failing to examine Moore and failing to perform another CT scan. Later that evening, Moore again complained of increased pain and headaches even though he had been given pain medication. The nursing staff notified Eckman of these complaints and also of Moore's increased blood pressure. After being so notified, Eckman failed to conduct a neurological exam and also failed to order CT scans. Instead, Eckman ordered blood pressure medication. Plaintiffs' expert testified that Eckman's failure to examine Moore and his failure to order a CT scan was a breach of the standard of care and that if Eckman had ordered such a scan, it would have revealed a subdural hematoma. Even though Moore was given blood pressure medication at 7:00 p.m. that evening, his blood pressure continued to increase. Eckman was again contacted by the nursing staff around 10:30 p.m. and again informed of Moore's terrible headaches and increased blood pressure. Rather than conducting an exam, Eckman ordered that Moore be given pain medication and that the neurological checks be given every four hours, rather than every two. Plaintiffs' expert testified this was another breach by Eckman and that if Eckman had conducted an exam and a CT scan, he would have discovered a subdural hematoma which could have been surgically drained at that point, thereby preventing all or most of Moore's brain damage. Plaintiffs' expert further testified that there were no documented neurological checks by the nursing staff between 10:30 p.m. that evening and 6:00 a.m. the next morning. Eckman saw Moore on the morning of February 22, 1999, after Eckman had been notified of

In its original opinion, the court found no reversible error and affirmed the trial court's judgment.[188] Eckman petitioned for rehearing, arguing that any negligence on his part occurred before any negligence on the part of the nursing staff, and that therefore the jury should have been able to consider whether the nursing staff's negligence was an intervening and superseding cause which would relieve Eckman of any liability. Eckman did not challenge the sufficiency of the evidence against him or the amount of the verdict.

On rehearing, the court held that the trial court erred in failing to give a superseding cause instruction. In so holding, the court arguably misapprehended the circumstances in which such an instruction is appropriate. Generally, intervening negligence is not a superseding cause, especially when the intervening negligence is foreseeable.[189] Moreover, in cases such as this, where several liability, rather than joint and several liability, is imposed, there is no public policy reason to excuse the original tortfeasor's negligence simply because another tortfeasor's negligence intervened. The superseding cause rule was developed when joint and several liability was imposed thereby exposing the original tortfeasor to liability for all of the damages sustained by the plaintiff, even those caused by the intervening tortfeasor. In a comparative fault system, where each defendant is only required to pay that portion of damages which corresponds to the percentage of fault allocated to that defendant, the all-or-nothing superseding cause rule is not commonly applied in other jurisdictions because there is no risk that the original tortfeasor will be held liable for damages proximately caused by an intervening tortfeasor.[190] In holding that a superseding cause instruction should have been given, the court completely ignored the fact that, in allocating sixty percent of the fault to Eckman, the jury clearly found Eckman

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Moore's cardiac arrest. Eckman ordered a CT scan and an angiogram that day but did not perform surgery on Moore until February 23, 1999. Plaintiffs' expert testified that Eckman again breached the standard of care by failing to operate immediately after the scan was taken on February 22, 1999.

[188] *Eckman I*, *supra* note 185.

[189] DOBBS, *supra* note 109, § 192, at 476-477.

[190] *Id.* § 197, at 491.

to be the most culpable defendant.

The court also held that the trial court abused its discretion in admitting certain videos and photographs into evidence.[191] Even though some of the admitted photographs were merely cumulative, the court found their admission prejudicial.[192] Finally, although the court has previously held that attorneys are allowed wide latitude when making closing argument and that the trial court is in a much better position to judge any impropriety during closing argument, the court held that the plaintiffs' attorney's suggestion during closing argument that Eckman believed he was above the law was prejudicial error.[193]

The court's reversal of the judgment in *Eckman* and its recent reversal of large awards in other medical malpractice cases indicate that the current court is receptive to defense challenges to large jury verdicts in medical malpractice cases.[194] The court has also recently reversed or remitted large awards in other types of tort cases.[195] These recent cases sug-

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[191] *Eckman II*, 876 So. 2d at 986.

[192] The admission of cumulative evidence usually does not warrant reversal. *See, e.g.*, Dixon v. Int'l Harvester Co., 754 F.2d 573, 582 (5th Cir. 1985) ("The improper admission of evidence that is merely cumulative to properly admitted evidence is harmless error.").

[193] *Eckman II*, 876 So. 2d at 987; *see* Alpha Gulf Coast, Inc. v. Jackson, 801 So. 2d 709, 727-28 (Miss. 2001) (holding that attorney's "send a message" argument was not error); James W. Sessums Timber Co. v. McDaniel, 635 So. 2d 875, 882 (Miss. 1994) (noting that control over closing argument is left to discretion of trial judge who is in better position to observe); Nelms & Blum Co. v. Fink, 131 So. 817, 820 (Miss. 1930) (noting the wide latitude given counsel in closing argument).

[194] Other recent medical malpractice cases in which the court reversed judgments in favor of plaintiffs include *Rawson v. Jones*, 816 So. 2d 367 (Miss. 2001) (reversing a $1 million verdict in a wrongful death case based on a determination that the statute of limitations had run), and *Sullivan v. Washington*, 768 So. 2d 881 (Miss. 2000) (reversing a $1.7 million judgment based on a finding that defendants were "employees" for purposes of the MTCA).

[195] In *Entergy Miss., Inc. v. Bolden*, 854 So. 2d 1051, 1058 (Miss. 2003), the court remitted the jury's award of $532,000 in damages to $232,000. The plaintiff sustained knee, shoulder and ankle injuries in a motor vehicle accident. The plaintiff introduced proof of more than $41,000 in past medical expenses and past lost wages. The court held that the jury's award of almost $500,000 for noneconomic damages such as pain and suffering was not supported by the evidence even though the plaintiff underwent knee surgery, was still required to

gest that the current court, which is widely perceived to be more favorable to business interests, will carefully review any large damage awards, particularly those in medical malpractice cases.[196]

After reviewing: (i) the MMTRL and the GTRL, which substantially limit health care providers' exposure to liability; (ii) the MMIAA, which ensures the availability of liability insurance to all Mississippi health care providers; (iii) the Mississippi Supreme Court's recent amendment of Mississippi Rule of Evidence 702 and its adoption of the *Daubert* test governing the admissibility of expert testimony; (iv) the court's recent decision severely restricting mass joinder of medical malpractice claims against multiple physicians; (v) the court's recent amendment of Mississippi Rules of Civil Procedure 20, 42 and 82 limiting joinder and consolidation and authorizing transfer of venue based on forum non conveniens; and (vi) the court's

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engage in physical therapy at the time of trial, would likely develop arthritis and continue to walk with a limp, had two scars as the result of the accident and was assigned a modest permanent impairment rating as the result of the accident. *Bolden*, 854 So. 2d at 1064-65 (McRae, J., dissenting).

In *Illinois Central Railroad Co. v. Hawkins*, 830 So. 2d 1162 (Miss. 2002), the court reversed a $1.5 million jury verdict in favor of a mother whose claim for negligent infliction of emotional distress was based on her observation of a collision between a train and a car driven by her daughter. The plaintiff's daughter and two grandsons were killed in the collision. The court found the plaintiff's testimony regarding nightmares, sleeplessness and visits to the psychiatrist insufficient to support any award of damages for emotional distress and therefore reversed the verdict in favor of the mother. *Hawkins*, 830 So. 2d at 1175.

In *Diamond Offshore Management Co. v. Marks*, No. 2000-CA-01680-SCT, 2003 WL 556438 (Miss. Feb. 27, 2003), a Jones Act case in which the trial court awarded the plaintiff approximately $3.6 million after a bench trial, the Mississippi Supreme Court remitted the award by $2 million even though the plaintiff established more than $650,000 in economic damages, was permanently and totally disabled, was unable to return to work, was unable to sit for long periods of time and was unable to play with his children in any meaningful way.

In *Janssen Pharmaceutica Inc. v. Bailey*, 878 So. 2d 31 (Miss. 2004), the Mississippi Supreme Court reversed a $48 million judgment in favor of ten plaintiffs finding that joinder of their product liability claims against Janssen and its parent company was inappropriate. The plaintiffs in this case had not brought malpractice claims against the prescribing physicians. *See supra* note 176.

[196] *See, e.g., Houpt Reminisces*, *supra* note 141, at 6 ("In recent years, there have been favorable changes related to the Supreme Court . . . ."); Morris, *supra* note 186, at A1 ("Observers generally regard this court as more conservative . . . .").

reversal of substantial judgments in numerous recent cases, it is evident that significant statutory and judicial reforms have been implemented which substantially curtail health care providers' exposure to medical malpractice liability.[197]

III. EXAMINATION OF DATA

Given that substantial reforms have recently been implemented which will impact the Mississippi medical malpractice liability insurance market, the Mississippi Legislature should carefully examine available data to determine whether additional tort reform measures, such as a $250,000 cap on noneconomic damages or a mandatory medical review panel, will reap benefits sufficient to warrant their enactment.

A. Examination of MACM's Financial Performance During Recent Years

In 1976, in response to the medical liability insurance crisis of the mid-1970s, members of the Mississippi State Medical Association incorporated Medical Assurance Company of Mississippi, Inc. (MACM).[198] In 1977, the Mississippi Legislature passed legislation authorizing the formation of physician-owned nonprofit medical liability insurance corporations.[199] MACM converted to a nonprofit corporation and is now governed by the 1977 legislation which exempts MACM from most state insurance laws and regulations.[200] Although MACM must meet minimum capital and surplus requirements and file an annual statement with the insurance commissioner, MACM is not required to pay state taxes, is not subject to rate regulation, is not required to participate in the state's guaranty fund and is not limited in its investments.[201]

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[197] *See, e.g., Slow Improvement*, *supra* note 142 (quoting a representative of the Mississippi State Medical Association as saying "[t]he severity of awards is down, courts are reducing awards, cases are being dismissed on summary judgments and cases that are going to court are being won by the doctors").

[198] It was originally entitled the Mississippi Medical Fraternal and Educational Society. A.M. BEST CO., BEST'S INSURANCE REPORTS 2872 (2003).

[199] MISS. CODE ANN. § 83-47-1 et seq. (1999).

[200] *Id.* § 83-47-3.

[201] Mississippi Code Annotated section 83-47-7 establishes minimum capital and

MACM now insures at least 2600 physicians practicing in Mississippi and is the largest writer of medical malpractice insurance in the state, with approximately seventy percent of the market.[202] Given MACM's long-term and now substantial presence in the Mississippi market, it would be difficult to examine the current medical malpractice insurance market in Mississippi without carefully reviewing MACM's performance.

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reserve requirements for physician owned nonprofit insurers. Mississippi Code Annotated section 83-47-13 requires physician-owned nonprofit insurers to file annual statements. Mississippi Code Annotated section § 83-47-23 exempts physician owned nonprofit insurers from participation in the guaranty fund. Non-exempt insurers are limited in the investments they may make pursuant to Mississippi Code Annotated section 83-19-51. Non-exempt insurers are subject to rate regulation pursuant to Mississippi Code Annotated section 85-2-3(a), which provides that rates shall not be excessive, inadequate or unfairly discriminatory. Mississippi Code Annotated section 85-2-3(b) provides that a rate is excessive if it is likely to produce a profit that is unreasonably high for the insurance provided or if the expense provision included therein is unreasonably high in relation to the services rendered.

Arguably, these exemptions give MACM a competitive advantage in the Mississippi market. In addition, because MACM is physician owned, each physician in good standing has an equity account. Insured physicians are only entitled to receive a distribution of this account upon retirement, death or disability. If a physician simply switches to another carrier, the physician forfeits any right to the equity account. The average equity account approximates $23,000 (MACM's surplus of approximately $60 million divided by its 2600 insureds). Another attractive feature of MACM's coverage is that physicians are entitled to a free extended reporting endorsement, often referred to as "tail" coverage, upon death, disability or retirement after at least five years of coverage. Purchasing "tail" coverage for claims made after retirement can be expensive. Thus, offering an equity account and a free extended reporting endorsement to those physicians who continue to purchase coverage from MACM gives MACM some leverage in the market because physicians who have equity accounts and/or who are entitled to a free tail coverage have a disincentive to seek coverage from an alternative carrier. A.M. BEST CO., BEST'S INSURANCE REPORTS 2869-70 (2003); A.M. BEST CO., BEST'S INSURANCE REPORTS 2881 (2001).

[202] *Houpt Reminisces*, *supra* note 141, at 2; Houpt Testimony, *supra* note 72, at 273.

Chart 5. MACM's Gross and Net Written Premiums 1994-2003 (millions)[203]

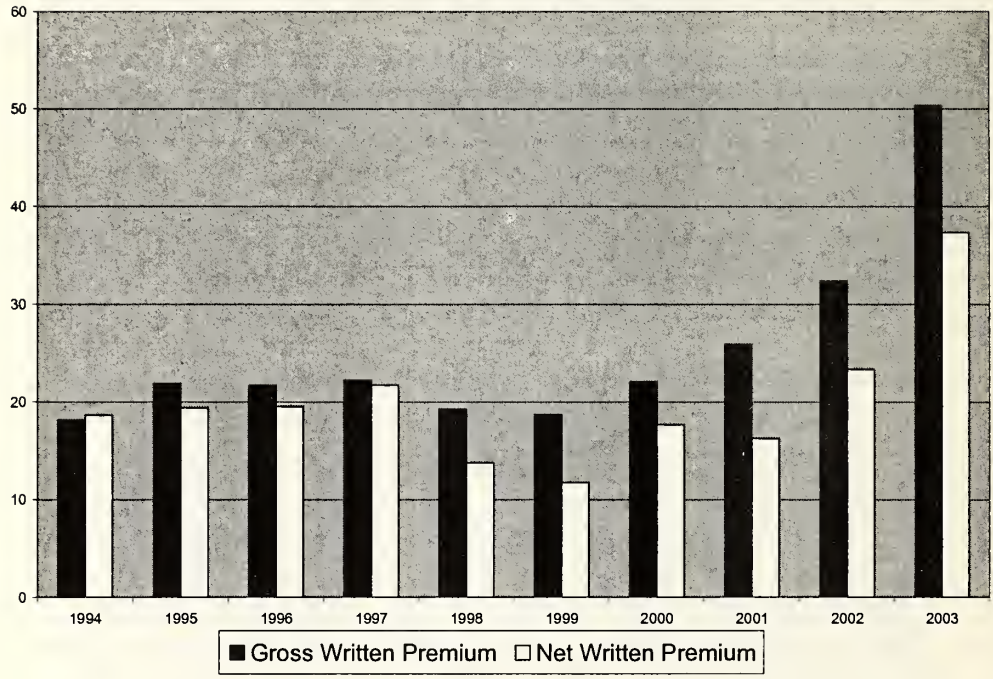

Chart 5 demonstrates that the gross premiums written by MACM have greatly increased over the last ten years, rising from approximately $18 million in 1994 to approximately $50 million in 2003. Some of the increase can be explained by the fact that MACM is now insuring many more physicians than it was in 1994. A large part of the increase, however, can be at-

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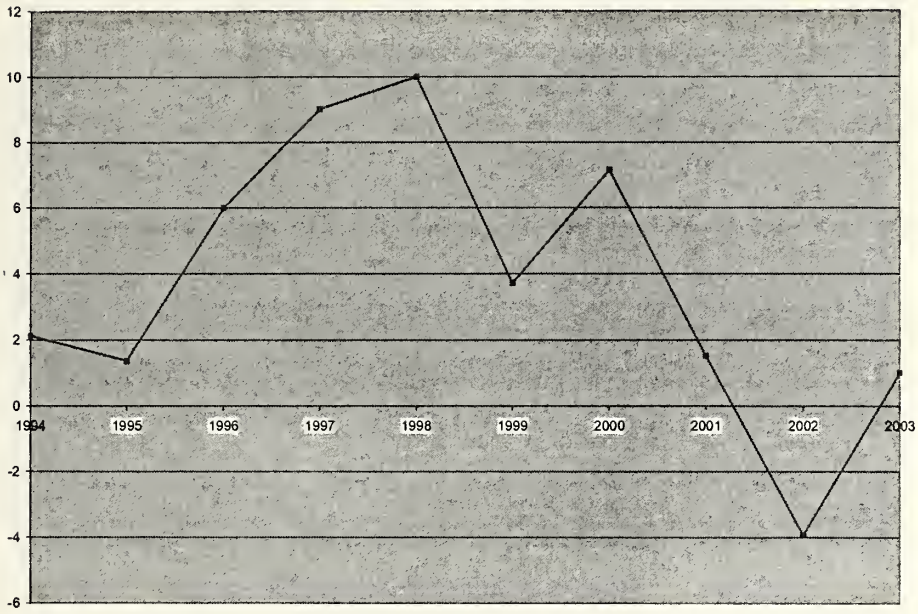
[203] *See* MACM, 1998-2003 ANNUAL STATEMENTS (1999-2004). "Gross Premiums Written" for 2003 indicates the total amount of premiums charged by MACM for all policies written in 2003. "Net Premiums Written" reflects the total amount of gross premiums written which will be retained by MACM, rather than ceded to a reinsurer as payment for reinsurance. In 2003, for example, MACM ceded more than $13 million in premiums to its reinsurers. MACM, 2003 ANNUAL STATEMENT 42 (2004).

tributed to significant increases in MACM's rates for 2002 and 2003.[204]

Chart 6. MACM's Net Income 1994-2003 (millions)[205]



As Chart 6 demonstrates, even though MACM raised its rates in recent years, its net income has fluctuated considerably, peaking in 1998, when MACM earned almost $10 million, and reaching a low in 2002, when MACM lost almost $4 million. Despite claims that it is impossible for malpractice insurers to earn a profit in Mississippi's current legal climate, MACM earned a net profit of almost $1 million in 2003.

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[204] For a detailed examination of MACM's rates, see *infra* text accompanying notes 268-94.

[205] *See* MACM, 1998-2003 ANNUAL STATEMENTS, *supra* note 203.

Table 1. Components of MACM's Net Income 1994-2003 (in thousands)[206]

Year	A. Net Underwriting Profit/(Loss)	B. Investment Income	C. Recognized Capital Gain	Net Investment Gain (B+C)	E. Other Income	C. Federal Taxes	G. Net Income (A+D+E-F)
1994	(2,307)	5,415	(260)	5,155	6	730	2,125
1995	(5,067)	6,202	1,262	7,464	19	1,057	1,359
1996	(3,011)	6,537	5,818	12,355	72	3,413	6,002
1997	(1,943)	6,984	6,917	13,901	21	2,969	9,010
1998	(6,634)	7,752	13,124	20,876	55	4,311	9,985
1999	(11,369)	7,467	8,824	16,291	19	1,222	3,718
2000	(7,349)	8,583	8,348	16,931	38	2,483	7,136
2001	(8,149)	7,749	1,435	9,185	3	(473)	1,512
2002	(13,982)	7,362	(294)	7,068	47	(2,939)	(3,929)
2003	(10,617)	7,034	4,910	11,944	22	350	999

As Table 1 indicates, MACM has experienced an underwriting loss every year for the past decade. MACM's investment income, largely derived from its bond investments, increased from 1994 to 1998, in large part due to the increase in the value of MACM's invested assets. As interest rates dropped in recent years, however, MACM's investment income decreased even as the value of its invested assets continued to increase.

More enlightening, however, is the degree to which

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[206] *See* MACM, 1998-2003 ANNUAL STATEMENTS, *supra* note 203; A.M. BEST CO., BEST'S INSURANCE REPORTS 2784 (1998) (data in columns B & C for years 1994 to 1997). In addition to investment income, insurers also report miscellaneous income and expenses not related to underwriting or investment activity as "other income." Other income includes finance or service charges not included in premiums as well as write-offs for uncollectible premiums. BASIC CONCEPTS, *supra* note 41, at 56; TROXEL & BOUCHIE, *supra* note 41, at 168.

MACM's recognized capital gain has fluctuated. MACM's recognized capital gain decreased from a high of more than $13 million in 1998 to a net loss of almost $300,000 in 2002. From 1998 to 2002, MACM's net investment gain decreased by more than $13.8 million from almost $20.9 million to less than $7.1 million, while its underwriting loss increased by approximately $7.4 million, from $6.6 million to $14 million. Thus, from 1998 to 2002, the decline in MACM's net investment gain was actually greater than the increase in its underwriting loss, indicating that MACM's decreasing net investment gain, rather than its deteriorating underwriting results, was primarily responsible for the decline in MACM's net income from 1998 to 2002.

In 2003, MACM benefited from the rising stock market, recognizing almost $5 million in capital gains.[207] With these gains and its $7 million return on its bond investments, MACM was able to offset its underwriting loss of more than $10 million and earn a profit of almost $1 million.

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[207] In 2003, MACM invested 28.4% of its invested assets in stocks. MACM, 2003 ANNUAL STATEMENTS 24 (2004).

Table 2. MACM's Percentage of Investment in Stock Compared to the Industry's Percentage of Investment in Stock

Year	Percentage of Investments in Stocks (MACM)[208]	Percentage of Investments in Stocks (Industry)[209]	Dow Jones Industrial Average[210]	Annual Yield for 10-Year AAA-rated Corp. Bonds[211]
1994	20.5	6.8	3,834	
1995	29.3	7.5	5,117	6.93
1996	26.6	9.8	6,448	5.74
1997	31.3	11.0	7,908	6.66
1998	27.8	11.0	9,181	5.74
1995	29.3	13.3	11,497	6.38
2000	30.7	12.1	10,787	7.09
2001	30.1	11.2	10,022	5.92
2002	26.3	9.5	8,342	5.42

[208] *See* MACM, 2002 ANNUAL STATEMENT 22 (2003); MACM, 1998 ANNUAL STATEMENT 21 (1999). The figure reflects the percentage of total admitted assets in cash and investments which is invested in stock, as opposed to bonds, real estate, cash or other investments.

[209] *See* A.M. BEST CO., BEST'S AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 335 (2003) (reflecting, in data for 1998 to 2002, the percentage of total admitted assets in cash and investments which was invested in stock by insurers predominantly selling medical malpractice insurance.); A.M. BEST CO., BEST'S AGGREGATES AND AVERAGES: PROPERTY-CASUALTY 130 (1998) (reflecting, in data for 1994 to 1997, the percentage of total admitted assets in cash and investments which was invested in stock by insurers predominantly selling medical malpractice insurance).

[210] *See* Dow Jones Indexes, *Dow Jones Industrial Average Historical Performance*, *available at* http://www.djindexes.com/downloads/xlspages/DJIA_Hist_Perf.xls (last visited Apr. 10, 2004) (indicating the average at the end of the year).

[211] *See* MULTIPLE FACTORS, *supra* note 1, at 25 (reporting data as early as 1995).

As Table 2 indicates, MACM, which is not subject to any limitation on the amount it invests in the stock market, consistently invests a much larger percentage of its assets in stocks than most insurers in the industry. As interest rates began to decline and the stock market continued to rise, MACM began to invest an even higher percentage of its assets in the stock market. This strategy paid off from 1996 to 2000, when the stock market surged. However, when the stock market declined in 2001 and 2002, MACM's investment gain substantially decreased. It is evident that MACM's relatively large stock position has been a major cause of the variability in its profits.

Table 3. Changes in MACM's Surplus (in thousands)[212]

Year	Net Income	Net Unrealized Capital Gains	Change in Surplus	Surplus at Year End	NPW/ Surplus Ratio (MACM)	NPW/ Surplus Ratio (Industry)
1994	2,125	(958)	826	22,401	.83	.7
1995	1,359	6,299	7,287	29,688	.65	.6
1996	6,002	3,235	8,800	38,488	.51	.5
1997	9,010	4,874	13,194	51,682	.42	.5
1998	9,985	(3,230)	5,605	57,287	.24	.5
1999	3,718	(2,959)	(708)	56,579	.21	.5
2000	7,136	(4,645)	1,015	57,594	.31	.6
2001	1,512	1,484	2,391	59,986	.27	.7
2002	(3,929)	(8,721)	(13,980)	46,006	.51	1.0
2003	999	14,733	14,238	60,244	.62	

[212] *See* MACM, 1998-2003 ANNUAL STATEMENTS, *supra* note 203 (for MACM data); A.M. BEST CO., BEST'S INSURANCE REPORTS 2871 (2003) (for 1998 to 2002 industry data); A.M. BEST CO., BEST'S INSURANCE REPORTS 2785 (1998) (for 1994 to 1997 industry data). The 2003 industry NPW/surplus ratio is not yet available.

In addition to the effect MACM's recognized capital gain had on its net income in recent years, its recognized and unrecognized capital gain also had a substantial impact on its surplus. Given that unrecognized capital losses decrease an insurer's surplus, MACM's surplus, which is entirely invested in the stock market, is extremely sensitive to fluctuations in the stock market.[213] During the recent crisis, MACM's surplus was severely reduced due to MACM's losses in the stock market. As Table 3 indicates, the value of MACM's investment portfolio decreased by more than $8.7 million in 2002. Thus, in 2002, when MACM earned approximately $23.4 million in net premiums, it lost almost $9 million in capital markets.[214] This $9 million loss contributed greatly to the almost $14 million decrease in MACM's surplus from 2001 to 2002. This substantial decrease in surplus limited MACM's ability to provide coverage to the many physicians who were applying for coverage from MACM after other insurers withdrew from Mississippi. As was recently admitted by MACM's director, Mike Houpt, MACM was forced to quit selling new policies in response to the lagging stock market.[215]

In 2003, the value of MACM's investment portfolio increased by more than $14 million, causing MACM's surplus to increase by almost the same amount. These severe swings in MACM's surplus are largely the result of MACM's stock position and, to the extent that MACM invests a larger percentage of its assets in stock than most insurers, the swings in MACM's

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[213] At the end of 2001, MACM's surplus was $59,985,656 and its stock holdings totaled $58,241,887. At the end of 2002, MACM's surplus was $46,005,548 and its stock holdings totaled $49,554,219. At the end of 2003, MACM's surplus was $60,243,916 and its stock holdings totaled $65,211,789. MACM, 2003 ANNUAL STATEMENT, *supra* note 203, at 2-3; MACM, 2002 ANNUAL STATEMENT, *supra* note 203, at 2-3.

[214] Of the $8.7 million in unrecognized capital losses, more than $8.46 million of the losses were in the stock market. In addition, MACM, recognized capital losses of almost $300,000. MACM, 2002 ANNUAL STATEMENT 12 (2003).

[215] *Policy Cuts Blamed on Economy*, CLARION-LEDGER (Jackson, Miss.), Mar. 9, 2003, at B2 ("The current crisis was created when the economy slowed down and MACM stopped earning as much on its investments . . . . As such, there is a finite amount of risk we can expose ourselves to, and, quite frankly, with our expansion we picked up and the amount of surplus we had, it wasn't right to keep writing more policies.").

surplus are likely to be more volatile than those experienced by other insurers. MACM's "aggressive common stock leverage" position has been considered a negative factor by A.M. Best, an insurance ratings company, even in the years during which MACM recognized considerable capital gains.[216] Thus, it is clear that the volatility of the stock market was not only a major factor contributing to the decrease in MACM's income in recent years, but was also a major factor contributing to the substantial decrease in MACM's surplus in 2002, which decrease forced MACM to quit selling new policies, thereby exacerbating the crisis.

While it appears the variability in MACM's profits in recent years has been caused in large part by fluctuations in the stock market, MACM's net income was also affected by an increase in gross paid losses. Gross paid losses consist of all payments made in a given year to settle claims or satisfy judgments.[217] Most of the payments made in a given year are made pursuant to policies sold in previous years.

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[216] A.M. BEST CO., BEST'S INSURANCE REPORTS 2869 (2003); A.M. BEST CO., BEST'S INSURANCE REPORTS 2884 (2000).

Table 4. MACM: Losses and Loss Expenses
1998-2003
(in thousands)[218]

Year	Gross Paid Losses	Losses Incurred	Loss Expenses Incurred	Number of Insureds at Year's End
1998	11,279	12,679	5,288	1917
1999	14,489	12,980	8,671	1986
2000	10,155	14,141	5,869	2050
2001	19,067	12,200	8,136	2203
2002	17,046	21,849	8,977	2502
2003	13,996	20,278	24,103	approx. 2600

As Table 4 indicates, MACM's gross paid losses fluctuated a great deal from 1998 to 2003, peaking in 2001 at more than $19 million.[219] Presumably, the large increase from 2000 to 2001 was one of the factors which prompted MACM to raise rates in 2002. Notably, however, since 2001, there has been a 26.6% decrease in paid losses even though MACM has continually insured more physicians. The decrease cannot be attributed to the cap, given that the cap only applies to cases filed after 2002. Most, if not all, of the losses paid in 2003 were paid in cases which were filed in earlier years. In the future, as losses are paid in cases to which the $500,000 cap applies, MACM's paid losses may decline even more.

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[218] *See* MACM, 1998-2003 ANNUAL STATEMENTS, *supra* note 203 (for loss and expense data); MACM, 2002 ANNUAL REPORT TO MEMBERSHIP 2 (2003) (for data for 1998 to 2002 reflecting number of insureds at the end of the year); *Houpt Reminisces*, *supra* note 141, at 2 (indicating that at the beginning of 2004, MACM insured over 2600 physicians).

[219] The peak in gross paid losses reported by MACM is consistent with the peak in the total amount of Mississippi payments reported to the National Practitioner Data Bank in 2001. Since 2001, the total amount of Mississippi payments reported to the National Practitioner Data Bank has also decreased substantially. See *infra* notes 248-49 and accompanying text.

Even though MACM's paid losses have fluctuated in recent years, MACM's net investment gain has fluctuated to an even greater extent, as indicated in Table 1. From 1998 to 2002, MACM's paid losses increased by less than $6 million. During that same time period, its investment gain decreased by $13.8 million. Thus, from 1998 to 2002, MACM's declining investment gain reduced MACM's net income by a greater extent than MACM's increasing paid losses.

As Table 4 indicates, MACM's incurred losses for 2002 and 2003 are substantially higher than in previous years. Incurred losses include the net losses paid by MACM in a given year plus any change in its loss reserves from the end of the previous year to the end of the accounting year.[220] Thus, the incurred loss figure is, in large part, an estimate of future payments and is greatly influenced by an insurer's reserving practices. The more conservative the insurer is in estimating future loss payments and establishing reserves, the higher its incurred losses will be. MACM is very conservative in its reserving practices.[221] Although conservative reserving may be advisable and necessary to a certain extent, excessive over-reserving can trigger unwarranted rate increases because an insurer's recent loss experience will appear more severe than it actually is.[222]

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[220] For a more detailed discussion of the manner in which incurred losses are calculated, see *supra* notes 43-53 and accompanying text and Appendix A.

[221] As noted by A. M. Best Company, MACM "continues to conservatively reserve for emerging claims" and has a "solid loss reserve position." A.M. BEST CO., BEST'S INSURANCE REPORTS 2869 (2003).

[222] TROXEL & BOUCHIE, *supra* note 41, at 93; BASIC CONCEPTS, *supra* note 41, at 29.

Table 5. Development of MACM's Incurred Net Losses and Defense and Cost Containment Expenses (in thousands)[223]

Year	Incurred Net Losses and Defense and Cost Containment Expenses Reported at Year End	Amount Reported After Four Years of Development	Percent Change Over Four Years	Amount Reported After Nine Years of Development	Percent Change Over Nine Years
1990	16,830	10,137	-39.8%	8,796	-47.7%
1991	21,794	16,737	-23.2%	14,774	-32.2%
1992	18,081	14,000	-22.6%	13,400	-25.9%
1993	23,530	15,048	-36.0%	14,585	-38.0%
1994	27,157	22,949	-15.5%	16,920	-37.7%
1995	21,837	18,571	-15.0%		
1996	21,101	16,881	-20.0%		
1997	24,513	18,203	-25.7%		
1998	24,888	18,303	-26.5%		
1999	31,417	26,420	-15.9%		

As Table 5 demonstrates, MACM substantially overestimates its losses and defense and cost containment expenses year after year. For example, at the end of 1990, MACM estimated that its incurred net losses and defense and cost containment expenses for policies for which premiums were earned

[223] See MACM, 2003 ANNUAL STATEMENT, sched. P, pt. 2, at 52 (2004) (data for 1994 to 1999); MACM, 2002 ANNUAL STATEMENT, sched. P, pt. 2, at 50 (2003) (data for 1993); MACM, 2001 ANNUAL STATEMENT, sched. P, pt. 2, at 50 (2002) (data for 1992); MACM, 2000 ANNUAL STATEMENT, sched. P, pt. 2, at 72 (2001) (data for 1991); MACM, 1999 ANNUAL STATEMENT, sched. P, pt. 2, at 72 (2000) (data for 1990).

in 1990 totaled $16.83 million. However, after nine years of development, MACM reduced that figure to approximately $8.8 million, indicating that in 1990, MACM overestimated its incurred losses and defense and cost containment expenses by almost forty-eight percent. MACM has already reduced its losses and defense and cost containment expenses incurred pursuant to 2002 policies by more than $4.3 million, a ten percent decrease based on one year of development.[224] MACM's substantial overestimation makes it difficult to analyze MACM's actual performance.[225] Moreover, it increases the possibility that MACM will implement unwarranted rate increases.[226] In addition, given that the historical evidence demonstrates that insurers substantially overestimated reserves during the previous crisis, there is a good chance that MACM's reserves for policies sold in 2003 will develop favorably and that MACM will earn a profit on those policies even greater than the profit it has estimated thus far.[227]

Referring back to Table 4, the recent increase in MACM's incurred loss expenses is more dramatic than the increase in incurred losses. MACM estimates that for every dollar it earned in net premiums in 2003, it will pay almost sixty-five cents for defense, cost containment and other loss expenses.[228] From 1998 to 2003, MACM's incurred loss expenses have risen by 356%. The $18.8 million increase in incurred loss expenses from 1998 to 2003 is much greater than the $7.6 million increase in incurred losses during the same period. In 2003,

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[224] MACM, 2003 ANNUAL STATEMENT, *supra* note 203, at 52.

[225] Although MACM's overestimation of reserves for policies sold in earlier years increases income in the accounting year during which the reserves are released, MACM's overestimation of reserves for policies sold during the accounting year reduces MACM's income in the accounting year. For a general discussion of how overestimating incurred losses and LAE distorts income, see *supra* notes 43-53 and accompanying text and Appendix A.

[226] TROXEL & BOUCHIE, *supra* note 41, at 93; BASIC CONCEPTS, *supra* note 41, at 29.

[227] For a discussion of the extent to which the medical malpractice overestimated its loss and loss expense reserves during the previous crisis, see *supra* notes 89-93 and accompanying text.

[228] MACM's incurred loss expenses ratio is 64.6. MACM, 2003 ANNUAL STATEMENT, *supra* note 203, at 25.

MACM incurred more in expenses and legal fees than it did in losses.

The increase in MACM's incurred losses and incurred loss expenses may be partially explained by MACM's conservative estimation of losses and defense costs. Another factor presumably affecting MACM's incurred losses and incurred loss expenses is the recent increase in the number of claims filed with MACM.[229] As Table 6 indicates, the number of claims filed with MACM by its insureds dramatically increased in 2002 and 2003.[230] In late 2002, plaintiffs filed numerous lawsuits to avoid application of the tort reform legislation that went into effect on January 1, 2003.[231] Many of the lawsuits filed in late 2002 were not served on the defendant health care providers until 2003, thereby increasing the number of claims filed with MACM by its insureds in 2002 and in 2003.[232] Of the many claims filed with MACM in 2002 and 2003, the substantial majority arose from mass tort cases in which the plaintiffs not only sued physicians on medical malpractice claims, but also sued drug manufacturers on various products liability claims.[233] Even though MACM expects the majority of these cases to be resolved "with little or no expense," it probably established conservative loss and loss expense reserves for all of these claims, thereby causing its incurred losses and loss expenses to substantially increase in 2003.[234]

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[229] MACM's defense costs may also be rising in response to increased fees charged by defense lawyers.

[230] A claim does not indicate that a lawsuit has been filed. Some claims are settled before a lawsuit is initiated.

[231] *Message from the President*, *supra* note 172, at 1.

[232] *Id.*

[233] *Id.* In its newsletter, MACM reported that 409 of the 715 lawsuits it received in 2002 were mass tort cases and that 1737 of the 2013 lawsuits it received from January through September of 2003 were mass tort cases. *Id.* Although MACM referred to "lawsuits" in its newsletter, it may have been referring to claims arising from lawsuits rather than individual lawsuits. At any rate, it appears that the vast majority of claims filed with MACM in 2002 and 2003 were claims arising from mass tort litigation. For a discussion of the AOC data concerning the number of cases in which medical malpractice is the primary claim, see *infra* notes 307-10 and accompanying text.

[234] *Message from the President*, *supra* note 172, at 1; *see also Slow Improvement*, *supra* note 142 (quoting a Mississippi State Medical Association representative as saying that many of the claims filed before January 1, 2003 have no

Table 6. Total Numbers of Claims Reported in Year Policy Issued (Claims-Made Coverage)[235]

Year	Number of Claims Filed with MACM
1994	590
1995	527
1996	805
1997	606
1998	540
1999	536
2000	673
2001	705
2002	1184
2003	2343

As previously discussed, the Mississippi Supreme Court's recent decision in *Jannsen* should significantly decrease the number of claims filed against physicians in mass tort cases, which should in turn significantly reduce future incurred losses and incurred defense costs. In addition, the data compiled by the Administrative Office of the Courts indicates that the total number of malpractice lawsuits declined substantially from 2002 to 2003.[236] To the extent that the increase in MACM's incurred losses and incurred loss expenses was caused by the increased number of claims arising from mass tort lawsuits, the court's *Janssen* decision should reverse that trend.

Thus, the information culled from MACM's Annual Statements reveals that: (i) MACM invests a much greater percent-

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merit and will be weeded out).

[235] MACM, 2003 ANNUAL STATEMENT, *supra* note 204, sched. P, pt. 5F, sec. 3B, at 95. The table reflects claims made against MACM by MACM's insureds pursuant to claims-made coverage, which comprises the large majority of coverage sold by MACM.

[236] See *infra* notes 304-12 and accompanying text.

age of its assets in the stock market than most insurers; (ii) from 1998 to 2002, the decline in MACM's recognized capital gains was a major factor causing its net income to decrease; (iii) MACM invests substantially all of its surplus in capital markets and is therefore exposed to severe swings in its surplus; (iv) in 2003, MACM was unable to write new policies due to the decline in its surplus which was in large part caused by its unrecognized capital losses of $8.7 million in 2002; (iv) although MACM's gross paid losses spiked in 2001, its gross paid losses have declined considerably since then even though the number of physicians it insures has consistently increased; (v) MACM is very conservative in its reserving practices and has consistently overestimated its incurred losses and incurred defense and cost containment expenses, making it highly likely that MACM will recognize additional profit from the sale of recent policies as its reserves develop and (vi) the recent increase in MACM's incurred losses and incurred loss expenses can be, at least partially, attributed to the large number of claims filed against MACM's insureds in mass tort cases, the frequency of which should significantly decrease in 2004 in light of the Mississippi Supreme Court's decision in *Janssen*.

B. Examination of the Data from the National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) was created by the Health Care Quality Improvement Act of 1986 in an attempt to decrease medical malpractice, improve the quality of health care and restrict the interstate movement of incompetent physicians by providing a means for potential employers to obtain information concerning past performance.[237]

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[237] 42 U.S.C. § 11101-52 (2000). The NPDB was intended to supplement traditional methods by which hospitals, state licensure boards and other health care entities investigate practitioners who they are interested in hiring or to whom they may grant privileges. Given that settlement of a malpractice claim does not always indicate malpractice has occurred, the data bank is intended to act as a flagging system which simply alerts medical and licensing boards that there may be a problem with a physician's competence, warranting further review. Nat'l Practitioner Data Bank/Healthcare Integrity and Prot. Data Bank, U.S. Dep't of Health and Human Servs., Fact Sheet on the National Practitioner Data Bank 1

Pursuant to the Act, which focuses primarily on physicians and dentists, state medical and dental boards are required to report certain adverse licensing actions related to a physician's or dentist's competence or professional conduct, such as revocation, suspension, reprimand and probation.[238] Health care entities are required to report any action which adversely affects a physician's clinical privileges.[239] In addition, entities which have made payments on behalf of a physician to settle a malpractice claim or to satisfy or partially satisfy a judgment in a malpractice action are required to report the name of the physician for whom payment has been made, the amount of the payment and the conduct giving rise to the action or claim.[240] All reports must be made to the NPDB within thirty days of the payment or adverse action.[241] Hospitals must make mandatory queries to the NPDB when a practitioner applies for privileges and must continue to make queries every two years for each practitioner who has obtained privileges.[242] Other eligible health care entities may voluntarily make queries.[243]

Although the NPDB does not release confidential data to non-eligible entities, it does make a data file available to the public which contains information concerning all reports of malpractice payments and adverse licensure actions but does not disclose the identity of practitioners or reporting entities.[244] Even though there are some limitations to the information contained within the NPDB, an analysis of the NPDB information is instructive given that it is the largest repository of detailed information concerning medical malpractice payments.[245]

(Oct. 11, 2001), *available at* http://www.npdbhipdb.com/pubs/fs/Fact%20Sheet%20%20National%20Practitioner%20Data%20Bank.pdf (last visited Apr. 10, 2004).

[238] 42 U.S.C. § 11132.

[239] 42 U.S.C. § 11133.

[240] 42 U.S.C. § 11131.

[241] 45 C.F.R. § 60.5 (2000).

[242] 42 U.S.C. § 11135.

[243] 42 U.S.C. § 11137.

[244] 45 C.F.R. § 60.11(a)(7).

[245] The NPDB does not require reporting of payments made on behalf of hospitals. Nor does it require reporting of payments made directly by physicians

For the period September 1, 1990 through December 31, 2003, the NPDB received 344,508 reports. For purposes of analysis, this Article focuses primarily on malpractice payment reports, rather than adverse licensing reports and other adverse actions reports, and limits its analysis to medical malpractice payment reports concerning allopathic physicians, allopathic interns and residents, osteopathic physicians and osteopathic interns and residents. Table 7 compares the mean and median malpractice payments made on behalf of Mississippi physicians for the years 1997 to 2003 to the mean and median malpractice payments made on behalf of physicians nationwide.[246] Despite claims that Mississippi malpractice awards are among the nation's highest, the Mississippi median payment for six of the last seven years has been equal to or lower than the national median payment. Moreover, the percentage increase in Mississippi's median payment from 1997 to 2003 was less than the percentage increase in the national median payment over the same period of time. In addition, Mississippi's mean payment was below the national mean pay-

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who are uninsured or underinsured. Am. Dental Ass'n v. Shalala, 3 F.3d 445, 447-48 (D.C. Cir. 1993). In addition, there is some concern that malpractice payments are underreported. Some insurers and other self-insured entities may simply fail to report. Hospitals or insurers making payments on behalf of physicians may also intentionally avoid reporting a payment made on behalf of a physician by omitting the physician's name from the settlement and substituting the name of a hospital, clinic or other entity, thereby avoiding disclosure. This "corporate shielding" most commonly occurs when the health care entity named in the settlement is also responsible for maintaining the physician's insurance. NAT'L PRACTITIONER DATA BANK, 2002 ANNUAL REPORT 25 (2003), *available at* http://www.npdbhipdb.com/pubs/stats/2002%20NPDB%20Annual%20Report.pdf (last visited Apr. 10, 2004). Acknowledging these limitations, the GAO recently found the NPDB data to be the most comprehensive source of data concerning claim costs. The GAO noted that Jury Verdict Research (JVR) was a potential source of similar data, but indicated that the accuracy of the JVR data has been questioned because JVR collects data in an unsystematic fashion and is more likely to include large awards rather than small awards. IMPLICATIONS, *supra* note 27, at 51-52.

[246] The mean payment is the average of all payments within the year. Half of the payments in a given year are larger than the median payment and half of the payments in given year are smaller than the median payment. Given that the mean payment can be greatly influenced by a few large payments, the median payment may be a more accurate indicator of typical payments amounts. NAT'L PRACTITIONER DATA BANK, 2002 ANNUAL REPORT, *supra* note 245, at 25.

ment in 1998, 2000, 2002 and 2003 and only exceeded the national mean payment in 2001 by about $16,000. Moreover, the 9.86% increase in Mississippi's mean payment from 1997 to 2003 was far outpaced by the 37.42% increase in the national mean payment over the same period of time. Thus, Mississippi's 2003 mean and median payments are below the national average and, from 1997 to 2003, the mean and median payments in Mississippi have grown by a smaller percentage than the national mean and median payments.

Table 7. National and Mississippi Mean and Median Malpractice Payments 1997-2003[247]

Year	Mississippi Mean Payment	National Mean Payment	Mississippi Median Payment	National Median Payment
1997	$246,250	$212,031	$ 97,500	$ 97,500
1998	$189,360	$219,055	$ 57,500	$ 97,500
1999	$249,246	$223,564	$145,000	$105,000
2000	$209,134	$245,722	$125,000	$125,000
2001	$281,334	$265,254	$135,000	$135,000
2002	$249,147	$270,922	$135,000	$105,000
2003	$270,533	$291,378	$145,000	$155,000
Increase From 1997 to 2003	9.86%	37.42%	48.72%	58.97%

Table 8 indicates the total number of payments made on behalf of Mississippi physicians each year and the total amount of such payments. As is demonstrated, the number of reported payments in 2001 and 2002 was substantially higher than in previous years. In 2003, however, the number of reported payments decreased to only 113. From 1997 to 2003, the number of reported payments decreased by 12.4%. Although the total amount of reported payments increased substantially in 2001, it has decreased significantly since then.

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[247] *See* U.S. Dep't of Health and Human Servs., Div. of Practitioner Data Banks, National Practitioner Data Bank Public Use Data File (Mar. 16, 2004). The Author conducted various statistical analyses on the data contained in the NPDB public data file. Examination was limited to malpractice payments made on behalf of allopathic physicians, allopathic interns and residents, osteopathic physicians and osteopathic interns and residents. Reports of payments made on behalf of dentists, pharmacists, nurses and other health care providers were excluded from the Author's study. The reports are categorized by the NPDB according to the year in which they are processed by the NPDB. Thus, a report made in January of 1998 might actually reflect a payment made in December of 1997. Although categorizing the records according to year of origin does not perfectly portray the actual timing that all payments were made, such categorization does allow the observer to make year-to-year comparisons of the number of payments and the amount of the mean and median payments.

The total amount of payments reported in 2003 is actually less than the total amount of payments reported in 1997. Thus, although the data indicates that the total amount paid by insurers and other entities on behalf of Mississippi physicians spiked in 2001, the data also indicates that the total amount paid in 2003 and the total number of payments reported in 2003 are actually lower than the total amount paid and total number of payments reported in 1997. Again, this decrease cannot be attributed to the cap given that the large majority of payments made in 2003 were likely made in cases to which the 2002 tort reform legislation did not apply. As cases to which the cap applies are settled, the total amount paid is likely to decrease even more.[248]

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[248] The reports filed with the NPDB during the first three months of 2004 indicate that only sixteen malpractice payment reports were made on behalf of Mississippi physicians. The Mississippi mean payment reported in the first quarter of 2004 was $213,797, substantially lower than the corresponding national mean payment of $316,132 and the 2003 Mississippi mean payment of more than $270,000. The Mississippi median payment reported in the first quarter of 2004 was $78,750, substantially lower than the corresponding national median payment of $185,000 and the 2003 Mississippi median payment of $145,000. U.S. Dep't of Health and Human Servs., Div. of Practitioner Data Banks, National Practitioner Data Bank Public Use Data File (May 24, 2004). Again, the Author's analysis concerned only allopathic and osteopathic physicians and interns.

Table 8. Percentage Increase in Number of Mississippi Payments/Year And Total Amount of Reported Payments/Year[249]

Year	Number of Payments	Total Amount of Payments/Year
1997	129	$31,766,250
1998	116	$21,965,750
1999	112	$27,915,500
2000	116	$24,259,550
2001	146	$41,074,750
2002	158	$39,365,250
2003	113	$30,570,250
Percentage Change From 1997 to 2003	-12.4%	-3.8%

Closer examination of the data suggests that the increase in the total amount of payments reported in 2001 and 2002 cannot be easily attributed to excessive judgments. When payments are reported to the NPDB, the reporter is required to indicate whether the payment was made to settle a claim or to satisfy a judgment. The NPDB indicates that only two payments were made from 1996 through 2003 to satisfy million dollar judgments. A $995,000 payment was reported in 1997 as the result of a judgment entered in an obstetrics case and a $1,450,000 payment was reported in 2001 as the result of a judgment entered in a case where the physician failed to diagnose the patient.[250] Data concerning payments to satisfy judgments, however, is not indicative of overall claims severity given that the vast majority of payments are made pursuant

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[249] *See* U.S. Dep't of Health and Human Servs., *supra* note 247.

[250] The NPDB codes payments made from $100,001 to $1,000,000 at the midpoint of $10,000 increments. Thus, a $1,000,000 payment is coded as $995,000. Therefore, all $995,000 payments in the data bank were treated as million dollar payments. The NPDB codes payments from $1,000,001 to $10,000,000 at the midpoint of $100,000 increments.

to settlement agreements. Relatively few medical malpractice cases are tried and many of those that result in a judgment are settled.

An examination of all Mississippi payment reports equal to or greater than $995,000 from 1997 through 2003 indicates that the number of million dollar payments fluctuates yearly. As Table 9 indicates, ten payments of at least one million dollars each were reported in 2001. Insurers, however, actually paid the greatest total amount in million dollar payments in 1997, when payments of $995,000, $995,000, $1,450,000, $2,950,000, $3,050,000 and $3,650,000 were reported.[251] In 2001, seven of the ten highest reported payments were for $995,000, one was for $1,250,000 and two were for $1,450,000. Thus, although more million dollar payments were reported in 2001, they were smaller than the million dollar payments reported in 1997, indicating that payments at the high end of the scale are decreasing rather than increasing.

Table 9. Mississippi Million Dollar Payments (1997-2003)[252]

Year	No. of Judgments	No. of Settlements	Total No. of Payments	Total Amount Paid
1997	1	5	6	$13,090,000
1998	0	5	5	$ 4,975,000
1999	0	7	7	$ 9,130,000
2000	0	2	2	$ 2,145,000
2001	1	9	10	$11,115,000
2002	0	6	6	$ 7,425,000
2003	0	6	6	$ 6,480,000

[251] A table of all of the million dollar Mississippi payments is included as Appendix B. There were three reports of payments for $995,000 or more which did not indicate whether the payment was made pursuant to a settlement or to satisfy a judgment. For purposes of the Author's evaluation, these three payments were treated as settlements and have been marked with an asterisk in the table in Appendix B.

[252] *See* U.S. Dep't of Health and Human Servs., *supra* note 247.

As indicated in Table 10, the highest reported payments were reported in 1995 and 1997, when four payments greater than $2 million were reported. From 1998 through 2003, only one payment exceeding $2 million was reported. Thus, the NPDB information actually indicates that fewer multi-million dollar payments were reported in the last five years than were reported in the previous five-year period.[253]

Table 10. Mississippi Payments for More than $2 Million (1990-2003)[254]

Year	Payment	Type of Claim
1995	$4,950,000	Failure to Diagnose
1997	$2,950,000	Failure to Diagnose
1997	$3,050,000	Monitoring - Failure to Report on Patient Condition
1997	$3,650,000	Obstetrics-Delay in Delivery: Induction or Surgery
2002	$2,450,000	Obstetrics-Improper Choice of Delivery Method

Comparing the data concerning physicians practicing in Mississippi to data concerning physicians practicing in states which have had a $250,000 cap on noneconomic damages for several years, specifically California, Colorado and Montana, it is not at all clear that establishing such a cap will result in payments that are lower than payments in states without such a cap or that establishing such a cap will cause payments to increase at a lower rate than in states without such caps.[255]

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[253] In California, which has had a $250,000 cap on noneconomic damages since 1975, there have been twenty-one payments in the last five years that were greater than $2 million, compared to only one such payment in Mississippi. Three of the twenty-one California payments exceeded $7.6 million. The highest reported payment in California was for $13.5 million in 1992. The highest reported payment in Mississippi was for almost $5 million in 1995. See *infra* note 255 for information concerning California's cap on noneconomic damages.

[254] *See* U.S. Dep't of Health and Human Servs., *supra* note 244.

[255] In 1975, California enacted the Medical Injury Compensation Reform Act (MICRA), which established, among other reforms, a $250,000 cap on

Table 11. Mean and Median Payments in States with a $250,000 Cap on Noneconomic Damages[256]

Year	California Mean Payment	California Median Payment	Colorado Mean Payment	Colorado Median Payment	Montana Mean Payment	Montana Median Payment
1997	$112,888	$37,500	$183,597	$ 87,500	$181,831	$ 72,500
1998	$139,205	$52,500	$284,982	$101,250	$119,382	$ 47,500
1999	$140,830	$52,500	$179,548	$ 72,500	$123,694	$ 32,500
2000	$140,058	$52,500	$234,160	$ 82,500	$232,784	$125,000
2001	$172,988	$62,500	$245,539	$125,000	$178,551	$ 97,500
2002	$174,780	$67,500	$262,425	$ 97,500	$202,715	$ 97,500
2003	$174,398	$57,500	$241,581	$115,000	$342,621	$195,000
Percent Change Since 1997	54.5%	53.3%	31.6%	31.4%	88.4%	169%

From 1997 to 2003, the national mean payment rose by 37.4%, California's by 54.5%, Colorado's by 31.6%, Montana's by 88.4% and Mississippi's by 9.8%. During the same time period, the national median payment increased by 59%, California's by 53.3%, Colorado's by 31.4%, Montana's by 169% and Mississippi's by 48.7%. Thus, not only did the mean and median payments in states which have had low caps for several years increase from 1997 to 2003, in many instances, the

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noneconomic damages in medical malpractice cases. CAL. CIV. CODE § 3333.2 (Deering 2004). In 1988, Colorado passed the Health Care Availability Act which capped noneconomic damages in medical malpractice cases at $250,000. COLO. REV. STAT. § 13-64-302 (Bradford 2002). By virtue of a 2003 amendment, the cap increased to $300,000 for acts or omissions occurring on or after July 1, 2003. In 1995, Montana established a $250,000 cap on noneconomic damages in medical malpractice cases. MONT. CODE ANN. § 25-9-411 (West 2003). It is difficult to use the NPDB data to examine payment amounts in states with a patient compensation fund because mean and median payments in those states would understate the actual amount paid to each plaintiff because there would be multiple reports for a single claim. For example, as discussed *supra* note 16, in Louisiana, a physician's primary insurer is only responsible for paying the first $100,000. The fund is responsible for any amount exceeding $100,000. Thus, for every Louisiana settlement or judgment exceeding $100,000, there would be two reports to the NPDB, one by the insurer and one by the fund itself.

[256] *See* U.S. Dep't of Health and Human Servs., *supra* note 247.

mean and median payments in states with low caps grew at a faster rate than the national and Mississippi mean and median payments, indicating that establishing a $250,000 cap on noneconomic damages does not guarantee that payment amounts will stabilize or increase at a slower pace than payment amounts in states without such caps.

The fact that payment amounts have risen substantially in recent years in states which have had low caps on noneconomic damages for several years suggests that economic damages may be responsible for a significant portion of the increase. This is not surprising. Often, plaintiffs in medical malpractice cases recover damages for past and future medical expenses. Costs for medical services increased by seventy-five percent from 1990 to 2002.[257] In addition, medical malpractice plaintiffs often incur past and future lost wages, which have increased over the last decade. For example, from 1990 to 2002, the average wage per job in Mississippi increased by fifty-two percent.[258] In addition, larger awards are necessary today to fully compensate plaintiffs for lost future wages and medical expenses given that the discount rate used to reduce such awards to present net value has decreased as interest rates have declined. Given that California, Colorado and Montana experienced substantial increases in their mean and median payments in recent years, the NPDB data does not support the conclusion that the recent increase in mean and median payments in Mississippi or elsewhere was primarily caused by an increase in awards for noneconomic damages, much less an increase in unwarranted or excessive awards for noneconomic damages.

Comparing current mean and median payment amounts, it appears that California's mean and median payments are significantly lower than the national mean and median pay-

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[257] Martin D. Weiss et al., *Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage* (2003), *available at* http://www.weissratings.com/MedicalMalpractice.pdf.

[258] *See* Bureau of Econ. Analysis, Regional Economic Accounts tbl. CA34 (indicating average wage per job increased from $17,200 in 1990 to $26,191 in 2002), *available at* http://www.bea.gov/bea/regional/reis/#ca34form.

ments, that Colorado's mean and median payments are moderately lower than the national mean and median payments and that Montana's mean and median payments are substantially higher than the national mean and median payments. According to the NPDB, California's mean and median payments are artificially low because an unusually large number of $30,000 payments are made in California in an attempt to avoid a state reporting requirement.[259] In 1998, 2000 and 2002, Mississippi's mean payment was lower than Colorado's mean payment.[260] In 2003, Mississippi's mean and median payments were lower than Montana's mean and median payments. Thus, the data do not support the proposition that establishing a $250,000 cap on noneconomic damages will necessarily result in mean and median payments that are substantially lower than the mean and median payments in states without such caps. Nor does it appear that the number of payments reported per capita is necessarily lower in states which have had low caps for several years. For example, the number of 2003 payments per capita is slightly higher in California than in Mississippi.[261] Moreover, as is discussed below in Section III.C., even though mean and median payment amounts in a state such as California may appear relatively low, current malpractice insurance rates in such states are not always lower than those in other states, suggesting that many factors influence insurance rates.[262] Thus, the NPDB data

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[259] NAT'L PRACTITIONER DATA BANK, 2002 ANNUAL REPORT, *supra* note 245, at 24 n.16. A California law requires insurers to report any physician settlement exceeding $30,000 to the Medical Board of California. CAL. BUS. & PROF. CODE § 801(b) (Deering 2003). In 2002, 1685 payments of $29,999 and 599 payments of $30,000 were reported in California. NAT'L PRACTITIONER DATA BANK, 2002 ANNUAL REPORT, *supra* note 245, at 24 n.16. Thus, it appears that an unusually high number of payments, almost twelve percent of the total number of payments reported in 2002, were made for $30,000 or $29,999 in an attempt to avoid the state reporting requirement.

[260] *See* tbls. 7 and 11. Colorado also caps all damages in medical malpractice cases at one million dollars, thereby placing additional downward pressure on payments. COL. REV. STAT. § 13-64-302(1)(b) (Bradford 2002).

[261] In Mississippi, where 2.845 million people reside, there were 113 payments reported. In California, where 33.872 million people reside, there were 1365 payments reported. MULTIPLE FACTORS, *supra* note 1, at 59, 62 (indicating Mississippi's and California's population).

[262] Noting that California's mean and median payments are lower than

contradicts any assumption that enacting a $250,000 cap on noneconomic damages will stabilize payment amounts or cause them to increase at a slower pace than payment amounts in states without such caps.

The NPDB data does reveal that relatively few Mississippi physicians are responsible for a substantial percentage of the total number of payments reported and the total amount paid since 1990. As Table 12 indicates, fifty-four percent of the total amount paid on behalf of Mississippi physicians since 1990 has been paid on behalf of physicians for whom at least two payments have been reported. Twenty-eight percent of the total amount paid on behalf of Mississippi physicians has been paid on behalf of physicians for whom at least three payments have been reported. Looking at the cumulative data, fewer than 394 physicians (less than ten percent of the total physicians practicing in Mississippi from 1990 to 2003) are responsible for fifty-four percent of the total amount paid.

Table 12. Cumulative Percentage of Payments Made on Behalf of Mississippi Doctors with Multiple Reported Claims (1990-2003)[263]

X Number of Payments	Total No. of Payments Made on Behalf of Physicians With X Payments	Percentage of Total Number of Payments	Percentage of Total Amount of Payments
At least 1	1513	100%	100%
At least 2	788	52%	54%
At least 3	408	27%	28%
At least 4	234	15%	16%
At least 5	120	8%	9%
At least 6	78	5%	6%
At least 7	43	3%	3%

Mississippi's mean and median payments, one might expect malpractice insurance in California to be substantially cheaper. As is discussed in more detail *infra* notes 273-94 and accompanying text, that is not always the case.

[263] See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 247.

As Table 13 indicates, in 2001, almost half of the total amount paid on behalf of Mississippi physicians was paid on behalf of physicians for whom at least three payment reports have been made. In 2002 and 2003, more than one quarter of the total amount paid was paid on behalf of physicians for whom at least three payment reports have been made.

Table 13. Percentage of Payments Filed on Behalf of Doctors with Multiple Reported Claims (2001-2003)[264]

Year	Number of Payments Made on Behalf of Physicians With 3 or More Reported Payments	Percentage of Total Number of Reports/Year	Percentage of Total Amount Paid/Year
2001	51 of 146	35%	49%
2002	47 of 158	30%	27%
2003	29 of 113	26%	26%

The data further indicates that in recent years, there have been physicians practicing in Mississippi for whom as many as seven, eight and nine payments have been reported. This suggests that more rigorous discipline by the state licensing board as well as increased risk management efforts could be extremely beneficial. Although not every payment indicates that the physician was negligent, it has been demonstrated that past claims experience is predictive of future claims experience.[265] In addition, it has been suggested that calculating rates based on a physician's individual experience rather than the experience of an entire pool of physicians in the same field

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[264] *Id.*

[265] At least one study has indicated that physicians with adverse claims experience have appreciably worse claims experience in later years. F.A. Sloan et al., *Medical Malpractice Experience of Physicians. Predictable or Haphazard?*, 262 JAMA 3291 (1989).

would not only give each physician a greater incentive to avoid malpractice and thereby reduce the number of claims, but would also reduce the cross-subsidization that presently occurs between low risk physicians and high risk physicians.[266] If insurance were experience rated, the physicians with an average or better claims history would pay much less for coverage than physicians with a troubling claims history. Experience rated insurance might also alleviate some of the problems caused by physicians who choose to limit their practice to curb the cost of coverage.[267]

Thus, the NPDB data demonstrates that: (i) current mean and median malpractice payments in Mississippi are lower than national mean and median payments; (ii) mean and median payments in Mississippi have increased at a lower pace than the national mean and median payments; (iii) the mean and median payments in Mississippi have increased at a lower pace than the mean and median payments in some states which have had low caps on damages for several years; (iv) the total number of payments made and total amount paid on behalf of Mississippi physicians spiked in 2001 and 2002, but decreased substantially in 2003 and (v) most of the payments made and most of the amount paid have been paid on behalf of physicians for whom multiple payments have been made—evidence which does not adequately support the enactment of additional tort reform measures but does suggest that more rigorous peer review and increased risk management would improve the market.

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[266] Gary M. Fournier & Melayne Morgan McInnes, *The Case for Experience Rating in Medical Malpractice Insurance: An Empirical Evaluation*, 68 J. RISK & INS. 255, 274-75 (2001); Frank A. Sloan, *Experience Rating: Does it Make Sense for Medical Malpractice Insurance?*, 80 AM. ECON. REV. 128, 132 (1990). Although some insurers do assess surcharges to physicians with a poor claims history, medical malpractice base rates are generally calculated based on the claims experience of the entire risk pool, rather than the individual. *See supra* notes 71-74 and accompanying text.

[267] Fournier & McInnes, *supra* note 266, at 274.

C. Examination of Insurance Rates Reported by Medical Liability Monitor

Medical Liability Monitor (MLM) has been annually surveying malpractice insurance rates in all states and the District of Columbia since 1991. MLM reports the rates charged by insurers for claims-made coverage for internal medicine, general surgery and obstetrics/gynecology with annual limits of $1 million for each claim and $3 million in the aggregate. The reported rates are base rates and do not reflect discounts, dividends or other factors which may decrease rates or surcharges which may increase rates. Although MLM collects the rate data from insurers on a voluntary basis, it estimates that its survey includes rates for sixty-five to seventy-five percent of the market.[268] As Charts 7, 8 and 9 below indicate, the reported Mississippi rates for all three classifications have increased substantially in recent years.[269]

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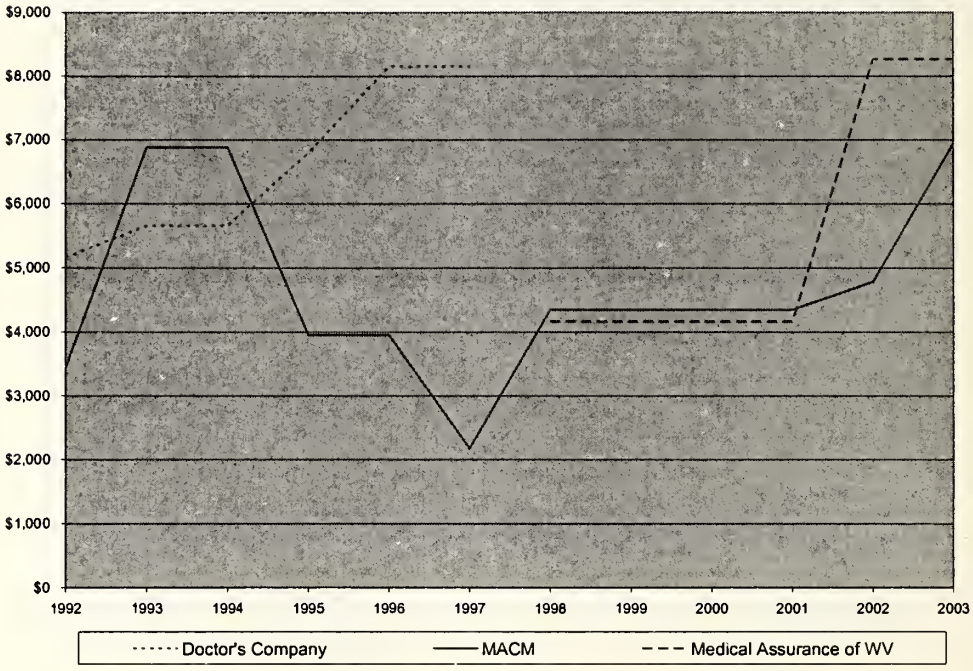
[268] *Rate Report Presents State-by-State Snapshot of Changing Market,* MED. LIABILITY MONITOR, Oct. 2003, at 1.

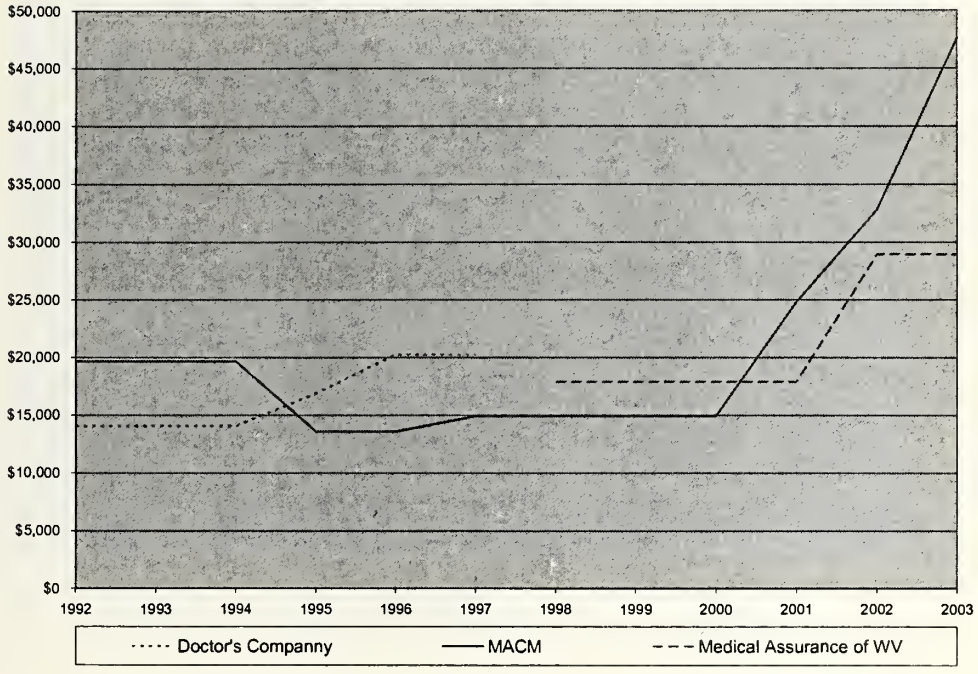
[269] Prior to 2001, medical malpractice rates for general surgery and obstetrics/gynecology in Mississippi had been relatively stable for many years. MACM had even been giving renewing physicians premium discounts of fifteen percent in 1998, twenty percent in 1999 and ten percent in 2000. A.M. BEST CO., BEST'S INSURANCE REPORTS: PROPERTY-CASUALTY 2884 (2002). MACM raised it rates by ten to thirty-two percent in 2002 and by an additional forty-five percent in 2003. *2003 Annual Rate Survey*, *supra* note 71, at 12; *2002 Annual Rate Survey*, MED. LIABILITY MONITOR, Oct. 2002, at 8. Although MACM's rates for internal medicine have risen in recent years, the 2003 rate is not much higher than the 1994 rate.

Chart 7. Mississippi Rates: Internal Medicine (1992–2003)[270]



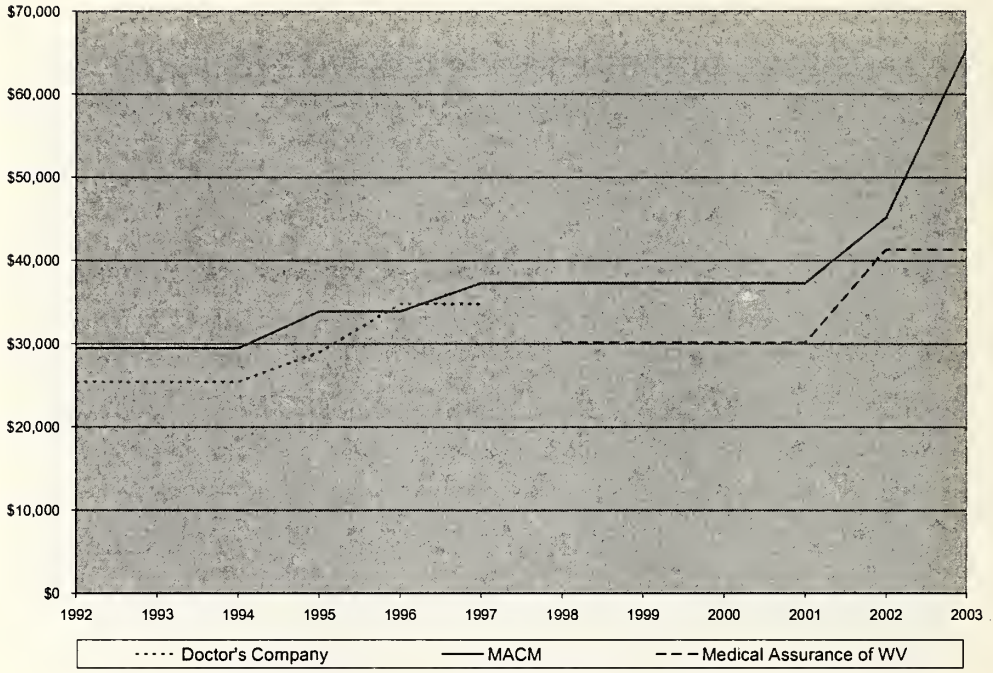
[270] 1992-2003 *Annual Rate Surveys*, MED. LIABILITY MONITOR, 1992-2003.

Chart 8. Mississippi Rates: General Surgery (1992 – 2003)[271]



[271] *Id.*

Chart 9. Mississippi Rates: Obstetrics/Gynecology (1992–2003)[272]



Although Mississippi rates have risen in recent years, similar rates and rate increases have been reported in other states which enacted tort reform measures several years ago. Charts 10, 11 and 12 compare the current range of reported rates for each risk classification in Mississippi to the current range of reported rates for each risk classification in California, Colorado, Montana, Florida, Nevada, Texas and Louisiana.

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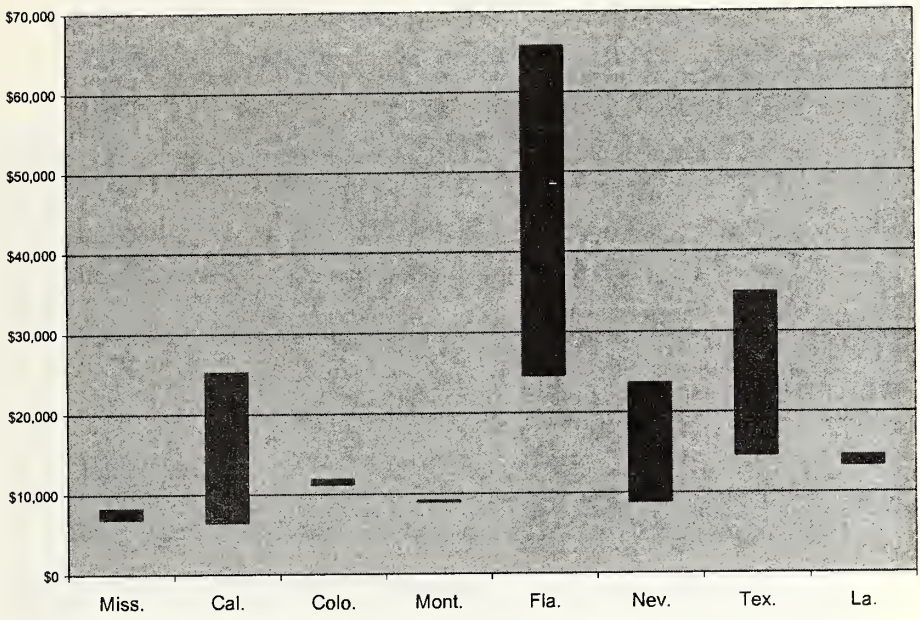
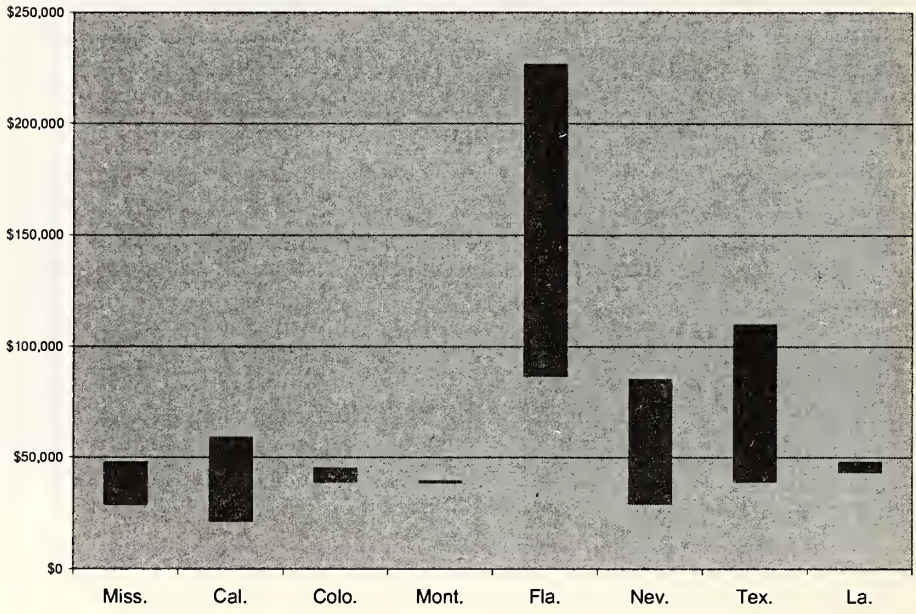
[272] *Id.*

Chart 10. Comparison of Range of Reported Rates for Internal Medicine in Mississippi to Range of Reported Rates in Other States (2003)[273]



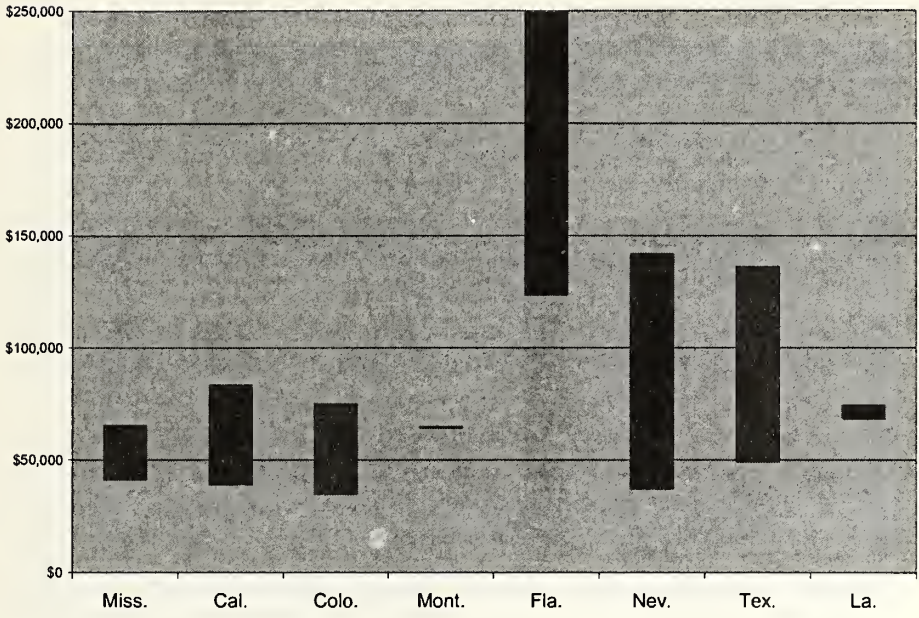
[273] *2003 Annual Rate Survey*, *supra* note 71. Insurers reporting rates for Mississippi, Colorado and Montana report rates that are the same throughout the state. The 2003 rate survey includes rates reported by two insurers for Mississippi, three insurers for Colorado and one insurer for Montana. Insurers reporting rates for California, Florida, Louisiana, Nevada and Texas report rates for different geographic regions within the state. The 2003 rate survey includes rates reported by six insurers for California, two insurers for Florida, one insurer for Louisiana, four insurers for Nevada and four insurers for Texas. Given that it is impossible to calculate weighted averages without detailed information concerning each insurer's market share in each state or region for each risk classification, the chart depicts the range of rates from the lowest rate reported in a state to the highest rate reported in a state. The reported rates for Louisiana include the insurance rates and the patient compensation fund surcharge.

Chart 11. Comparison of Range of Reported Rates for General Surgery in Mississippi to Range of Reported Rates in Other States (2003)[274]



[274] *Id.*

Chart 12. Comparison of Range of Reported Rates for Obstetrics/Gynecology in Mississippi to Range of Reported Rates in Other States (2003)[275]



It is evident that current rates in Mississippi are substantially lower than current rates in Florida, Nevada and Texas-other states which the American Medical Association has designated as crisis states.[276] For example, in 2003, the highest reported Mississippi rate for internal medicine was $8,264, compared to $65,697 in Florida, $23,620 in Nevada and $34,346 in Texas.[277] The highest reported Mississippi rate for general surgery was $47,592, compared to $226,542 in Florida, $85,024 in Nevada and $109,668 in Texas.[278] Similarly, the

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[275] *Id.*
[276] *See supra* note 5.
[277] *2003 Annual Rate Survey*, *supra* note 71, at 8-9, 12-13, 15-16.
[278] *Id.*

highest 2003 reported Mississippi rate for obstetrics/gynecology was $65,438, compared to $249,196 in Florida, $141,704 in Nevada and $136,020 in Texas.[279]

More importantly, however, in most instances, the range of 2003 reported rates in Mississippi for each classification is lower than or within the range of reported rates in California, Colorado and Montana, states which have had a $250,000 cap on noneconomic damages for several years.[280] For example, the highest 2003 reported rate for internal medicine in Mississippi is lower than the lowest such rate reported in Colorado and Montana and is lower than the lowest such rate reported by two of the three largest medical malpractice insurers in California.[281] The highest reported Mississippi rates for general surgery and obstetrics/gynecology are lower than many of the rates reported by NORCAL, California's largest insurer.[282]

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[279] *Id.*

[280] For a discussion of the caps in these states, see *supra* note 255.

[281] *2003 Annual Rate Survey*, *supra* note 71, at 6-8, 12. According to a 2002 market share report, NORCAL wrote more than twenty-five percent of the medical malpractice premiums in California, while The Doctors Company wrote sixteen percent and SCPIE wrote fifteen percent. Even though each of these insurers reported lower rates in northern California than elsewhere in California, all 2003 reported rates for internal medicine in Mississippi are lower than the lowest California rate for internal medicine reported by NORCAL and SCPIE. For market share data, see Cal. Dept. of Ins., *2002 California P & C Market Share Report, Line of Business: Medical Malpractice*, *at* http://www.insurance.ca.gov/docs/FS-Insurer.htm. The highest reported rates for the largest three insurers in California are in Los Angeles, Orange, Riverside, San Bernardino, San Diego and Ventura Counties, all counties in southern California where approximately fifty-seven percent of California's citizens reside. Thus, although rates reported for northern California are lower than the rates reported for southern California, it is likely that most physicians in California are paying rates at the high end of the range of reported rates, given that a much larger percentage of California's population resides in the southern counties for which the higher rates are reported. The average of all 2003 reported Mississippi rates for internal medicine is $7603, while the average of all reported California rates for internal medicine is $12,063. The average of all 2003 reported Mississippi rates for general surgery is $38,258, while the average of all reported California rates for general surgery is $34,867. The average of all 2003 reported Mississippi rates for obstetrics/gynecology is $53,379, while the average of all reported California rates is $53,369. For census data concerning California's population, see U.S. Census Bureau, *State and County Quick Facts*, *at* http://quickfacts.census.gov/qfd/states/06/06037.html.

[282] Reported Mississippi rates are lower than NORCAL's reported rates for the

When comparing the current Mississippi rates to those in Louisiana, which established a patient's compensation fund similar to the one being advocated by the Mississippi State Medical Association, all Mississippi rates for internal medicine and obstetrics/gynecology are actually lower than the lowest Louisiana rate for those classifications, even though Louisiana law mandates screening by a medical review board and caps a patient's total recovery, excluding future medical expenses, at $500,000.[283] Thus, the 2003 range of reported rates for Mississippi is not only substantially lower than the 2003 range of reported rates for other crisis states such as Florida, Nevada and Texas, but it is also, in most instances, lower than or within the 2003 range of reported rates for California, Colorado, Louisiana and Montana — states where tort reform measures have been in place for several years.

In addition to comparing current rates, it is also useful to compare the rate at which rates have increased in Mississippi to the rate at which rates have increased elsewhere. In 2002, MACM raised its base rates for internal medicine by 10%, for general surgery by 32% and for obstetrics/gynecology by 21%.[284] In 2003, MACM raised its base rates for all three classifications by 45%.[285] Rates in states which have had a low cap on noneconomic damages for several years have also risen substantially in recent years. For example, reported rates for all three risk classifications in Montana have risen by more than 100% since 2000.[286] In Colorado, which also has a low cap on noneconomic damages, the rates reported by The

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six southern California counties where the majority of California's citizens reside. Reported Mississippi rates are higher than NORCAL's reported rates for northern California. *2003 Annual Rate Survey*, *supra* note 71, at 6-7, 12. If Mississippi's risk pool were large enough to divide into more than one geographic region, rates in some regions would presumably be lower than the current rates for the entire state.

[283] For a discussion of Louisiana's Patient Compensation Fund, see *supra* note 16.

[284] *2002 Annual Rate Survey*, *supra* note 270, at 8.

[285] *2003 Annual Rate Survey*, *supra* note 71, at 12.

[286] *See 2003 Annual Rate Survey*, *supra* note 71, at 12; *2000 Annual Rate Survey*, *supra* note 270, at 9. The only 2003 Montana rates reported by *Medical Liability Monitor* are the rates charged by Utah Medical Insurance Ass'n.

Doctors Company for internal medicine have increased by 44% since 2000, while its reported rates for general surgery have increased by 73%.[287] There have also been substantial rate increases in California in recent years. NORCAL, the largest medical malpractice insurer in California, reported 2003 rate increases as high as 54% in some counties.[288] The Doctors Company, the second largest medical malpractice insurer in California, reported 2003 rate increases as high as 37% in some counties.[289] Since 2000, NORCAL has raised its rates for internal medicine in northern California by 65%.[290] MACM raised its Mississippi rates for internal medicine by only 60% over the same time period.[291] There is also evidence that California rates increased substantially during the previous crisis.[292] Thus, it is not at all clear that establishing a $250,000 cap on noneconomic damages in Mississippi will prevent substantial rates increases during a hard market, given that physicians in California, Colorado and Montana have experienced substantial rate increases in recent years. Nor is

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[287] The rates reported by COPIC Insurance, another insurer in Colorado, rose at a lower pace—by less than four percent in 2001, by approximately six percent in 2002 and by approximately thirteen percent in 2003. *2003 Annual Rate Survey*, *supra* note 71, at 8; *2002 Annual Rate Survey*, *supra* note 270, at 3; *2001 Annual Rate Survey*, *supra* note 270, at 3.

[288] *2003 Annual Rate Survey*, *supra* note 71, at 7.

[289] *Id.* at 6. NORCAL and The Doctors Company had reported rate increases of at least seven percent in these same counties in 2002. *2002 Annual Rate Survey*, *supra* note 270, at 1-2.

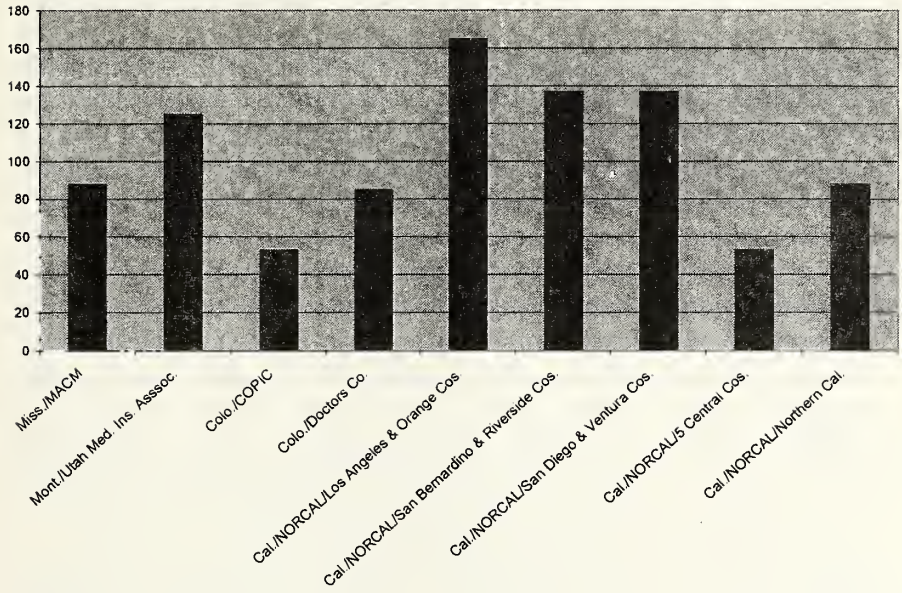
[290] *2003 Annual Rate Survey*, *supra* note 71, at 7; *2000 Annual Rate Survey*, *supra* note 270, at 2. Insurers typically charge physicians in northern California lower rates than they charge physicians in southern California.

[291] *2003 Annual Rate Survey*, *supra* note 71, at 12; *2000 Annual Rate Survey*, *supra* note 270, at 8.

[292] The GAO found that from 1980 to 1986, California medical malpractice rates had risen by as much as 337% and that, despite the enactment of MICRA, "the problem [was] continuing to worsen in California." U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REQUESTERS: MEDICAL MALPRACTICE: SIX STATE CASE STUDIES SHOW CLAIMS AND INSURANCE COSTS STILL RISE DESPITE REFORMS 26 (Dec. 1986). In addition, total premiums in California increased by forty-seven percent from 1985 to 1988 even though the cap had been in place for a decade and had been held constitutional in 1985. Found. for Taxpayer and Consumer Rights, *How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California* 3 (Mar. 7, 2003), *available at* http://www.consumerwatchdog.org/healthcare/rp/rp003103.pdf.

it evident that states with patient compensation funds are immunized from substantial rates hikes given that Louisiana rates increased by as much as 8.4% in 2001, by an additional fifteen percent in 2002 and by an additional 23.3 to 26.5% in 2003.[293]

Chart 13. Percentage Increase in Rates (1994-2003)[294]



[293] *2003 Annual Rate Survey*, *supra* note 71, at 18; *2002 Annual Rate Survey*, *supra* note 270, at 6-7; *2001 Annual Rate Survey*, *supra* note 270, at 7-8.

[294] *See 2003 Annual Rate Survey*, *supra* note 71; *1994 Annual Rate Survey*, *supra* note 270. The percentage increase indicated in the chart for each state or region is the average of the percentage increase for each of the three classifications within that state or region. For example, from 1994 through 2003, MACM raised its rates for internal medicine by 1%, for general surgery by 142% and for obstetrics/gynecology by 122%, for an overall average increase of 88%. For purposes of comparison, the average percentage increase in rates is indicated for all Mississippi, Colorado and Montana insurers for which

Chart 13 compares the percentage increase in rates for various geographic regions over the last decade. It is clear that, over the last decade, rate increases in Montana have outpaced those in Mississippi, even though Montana enacted a $250,000 cap in 1995. The data further demonstrates that, although one Colorado insurer's rates rose at a lower pace than MACM's, the other Colorado insurer's rates rose, on average, almost as much as MACM's. Finally, although the data indicates that rates increases in northern California were about twenty percent lower than the rate increases in Mississippi, the rate increases in southern California, where the majority of California's population resides, were substantially higher than the rate increases in Mississippi. Thus, the data indicate that rates in states which have had a low cap on noneconomic damages for many years have risen substantially in the last decade. Moreover, in many instances, the average rate increases reported over the last decade by insurers in California, Colorado and Montana have been comparable to, and even greater than, the average rate increases reported by Mississippi's largest insurer. Thus, given that there have been substantial rate increases in states which enacted tort reform measures several years ago, it is not evident that establishing a $250,000 cap on noneconomic damages in medical malpractice cases will immunize Mississippi physicians from substantial rate increases during future hard markets.

The Medical Liability Monitor data suggests that rates are affected not only by the amount of loss payments which are made for noneconomic damages, but also by many other factors.[295] Clearly, insurers' rates have increased in response to

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Medical Liability Monitor reported 1994 and 2003 rates. In addition, the percentage increase in rates reported by California's largest insurer, NORCAL, is indicated for the various geographic regions in which it reports rates. The five central California counties are San Mateo, Santa Clara, Santa Cruz, Fresno and Monterey. Comparison could not be made to rate increases by Louisiana insurers because *Medical Liability Monitor* did not report the fund surcharge for 1994.

[295] This conclusion is consistent with the conclusion reached in other studies. For example, Weiss Ratings, Inc. published a study of premiums nation-wide which concluded that caps did not necessarily lead to lower malpractice insurance rates, thereby suggesting that many other factors impact insurers' ratemaking, including medical inflation, the insurance business cycle, decline in

declining investment income, fluctuating capital markets and higher reinsurance costs.[296] In addition, insurers' ratemaking may also have been affected by a need to increase premiums in order to recover past losses incurred during the time period when fierce competition kept rates below cost.[297] Other factors driving rates higher are medical inflation and increasing wage rates, both of which have caused plaintiffs' economic damages to increase.[298] Lack of competition can cause rates to increase.[299] Currently, there is not much competition within Mississippi, given that few admitted insurers are selling coverage.[300] In addition, Mississippi's risk pool, particularly for certain specialties such as neurosurgery and obstetrics/gynecology, is very small, making it more difficult to predict future losses, thereby necessitating higher rates for these narrow specialties.[301] There is also evidence that insurers may be hesitant to enter the Mississippi market because they fear that the minority of physicians who are not insured by MACM pose greater risks than those who have been insured by MACM, thereby creating the possibility that new entrants to the Mississippi medical malpractice insurance market will suffer from adverse selection of high risk physicians.[302] Al-

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investment income and supply and demand. Weiss, *supra* note 257. See also MULTIPLE FACTORS, *supra* note 1, at 4.

[296] MULTIPLE FACTORS, *supra* note 1, at 4.

[297] Although insurers in a competitive market might not be able to raise rates to recover past losses, insurers in a noncompetitive market could. In MACM's September 19, 2002 letter notifying all policyholders of the forty-five percent increase in rates for 2003, MACM explained that the rate increase was necessary even though the legislature was considering tort reform because any tort reform would "not retroactively affect suits already pending or suits that fall within the statute of limitations and may be filed later." September 19, 2002 Letter from MACM to MACM Policyholders (on file with the Author). One could infer that MACM was, in part, justifying its rate increase based on pending lawsuits or lawsuits that could be filed before year-end, indicating that it may have been trying to recover past losses incurred as the result of under-pricing previous policies. It has been suggested that many insurers were forced to raise premiums in order to have adequate assets to strengthen reserves. *See, e.g.,* Weiss, *supra* note 257, at 4.

[298] *See supra* notes 257-58 and accompanying text.

[299] MULTIPLE FACTORS, *supra* note 1, at 4, 35.

[300] MDI REPORT, *supra* note 9.

[301] *Id.* at 8.

[302] *See, e.g.,* Letter from State Volunteer Mutual Insurance Company to

though rate regulation may have depressed rates in states such as California, rates are not heavily regulated in Mississippi.[303] When considering the rate data in light of these other factors which affect insurance rates within Mississippi, it is far from evident that replacing the current $500,000 cap on noneconomic damages with a $250,000 cap would reduce or stabilize malpractice rates in Mississippi.

D. Examination of Information Compiled by the Administrative Office of the Courts

The Administrative Office of the Courts (AOC) was established by the Mississippi Legislature in 1993 to improve the administration of justice in the state.[304] The AOC is required by statute to "collect, obtain, compile, digest and publish information and statistics concerning the administration of justice in the state."[305] In order to achieve this, the AOC compiles information obtained from the civil cover sheet of each civil lawsuit filed in the state.[306] As Table 14 indicates, there was

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George Dale, Mississippi Commissioner of Insurance (on file with the Author).

> We respectfully are curious whether SVMIC or any other carrier entering or expanding its presence in Mississippi would be expected to become a willing market for sub-standard risks that have been rejected by MACM. Since we are actively underwriting our own book of business and are screening new applicants carefully, we would have no interest in any scenario in which we would acquire an adverse selection of physician risks in Mississippi or any other territory.

Id.

[303] For example, in September of 2003, the California Insurance Commissioner denied a large insurer's request for a 15.5% increase and granted only a 9.9% increase. Reich, *supra* note 77. The same insurer withdrew a rate request for an additional 8.9% increase after consumer groups requested a hearing pursuant to Proposition 103. FTCR, *supra* note 77. For a discussion of rate regulation in Mississippi, see *supra* note 76.

[304] Act of Apr. 15, 1993, ch. 610, § 1, 1993 Miss. Laws 1119 (codified at MISS. CODE ANN. § 9-21-1 (Supp. 2003)).

[305] MISS. CODE ANN. § 9-21-3(2)(a) (Supp. 2003).

[306] When a civil lawsuit is filed in Mississippi, a Civil Case Filing Form must be completed by the plaintiff's attorney who must indicate the primary and secondary nature of the suit. Under "Torts--Personal Injury", there is a box which may be checked for "malpractice--medical." For a sample Civil Case Filing Form, see http://www.mssc.state.ms.us/AOC/default.asp. Attorneys are instructed to check one box in the first column that indicates the primary nature of the law-

a gradual increase in the number of filed medical malpractice cases from 1998 to 2001. Many factors might explain such a gradual increase, including deteriorating doctor-patient relationships, higher expectations of care based on better technology, an older population which experiences more illness and greater access to health care.[307] Table 14 also indicates that there was a substantial increase in the number of medical malpractice cases filed in 2002. The large increase was partially caused by the rush to file lawsuits prior to 2003 in order to avoid application of the MMTRL. There was also an increase in the number of mass tort cases involving pharmaceutical corporations and physicians as defendants.[308] As indicated by Table 14, the number of filed medical malpractice cases decreased dramatically in 2003.[309] As was acknowledged by the deputy director of governmental affairs for the Mississippi State Medical Association, there is "every indication the severity of claims and frequency is going to drop."[310] In addition, the Mississippi Supreme Court's recent *Janssen* opinion limiting the joinder of multiple malpractice claims against numerous physicians in cases involving pharmaceutical defendants should decrease the frequency of such claims.

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suit and then to check all boxes in the second column indicating the nature of secondary claims.

[307] MULTIPLE FACTORS, *supra* note 1, at 24.

[308] *See supra* notes 229-36 and accompanying text.

[309] The AOC data also suggests that the number of filed mass tort cases decreased in 2003.

[310] *See Slow Improvement*, *supra* note 142 (quoting the deputy director as saying that 600 cases were filed in the last two months of 2002 while only seven cases were filed in the first four months of 2003).

Table 14. Number of Medical Malpractice Cases Filed in Various Counties and Entire State 1998-2003[311]

Year	Hinds	Claiborne	Jefferson	Holmes	Jones	Entire State
1998	76	2	6	2	10	388
1999	94	0	6	3	7	444
2000	92	0	7	11	6	434
2001	124	0	2	4	5	474
2002	241	22	27	1	40	1132
2003	101	3	1	3	7	252

As Table 15 demonstrates, 187 of the 252 lawsuits filed in 2003, almost seventy-five percent, were concentrated in eleven of Mississippi's eighty-two counties. Less than five lawsuits were filed in the each of the remaining seventy-one counties. In 2003, in a majority of Mississippi counties, fewer than two medical malpractice cases were filed. In the vast majority of counties, medical malpractice lawsuits are rare. Surveying the eleven counties in which at least five claims were filed in 2003, several are very populous counties where numerous hospitals and other health care providers are located.

[311] Information contained in this chart was obtained from reports provided to the Author by the AOC (on file with the Author). The reports tally all cases in which medical malpractice was indicated as a primary claim for years 1998 to 2003. Although many of the cases included in the reports involve pharmaceutical defendants such as Johnson & Johnson, Wyeth, Bayer, Smithkline and Bristol-Myers, it is possible that some pharmaceutical cases involving medical malpractice defendants are not included given that the attorney may not have indicated medical malpractice as the primary claim. Statistics concerning the number of cases in which medical malpractice was indicated as a secondary claim were not available. The AOC indicated that, due to a conversion in its database, the figures for years before 2001 may not be exact but are representative.

Table 15. Mississippi Counties in Which More Than Four Medical Malpractice Lawsuits Were Filed in 2003[312]

County	No. of Lawsuits
Hinds	101
Harrison	24
Coahoma	9
Jackson	8
Jones	7
Lauderdale	7
Rankin	7
Washington	7
Lee	6
Adams	6
Hancock	5
Total in These Eleven Counties	187

Thus, the AOC data indicates that the number of medical malpractice filings decreased substantially in 2003. Although it is impossible to know whether that trend will continue, the AOC data does not provide adequate evidentiary support for the enactment of additional tort reform measures designed to reduce the number of medical malpractice cases. In the absence of strong evidence indicating a significant increase in the number of frivolous medical malpractice claims, reducing medical malpractice claim frequency is not necessarily a desirable goal, given the important compensatory and deterrent functions of medical malpractice liability.

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[312] *Id.*

CONCLUSION

Pursuant to the MMIAA, medical malpractice insurance is currently available to all health care providers in Mississippi. Thus, to the extent that there is a medical malpractice liability insurance crisis in Mississippi, it is limited to the affordability of malpractice coverage. As demonstrated in this article, numerous factors have caused malpractice rates for coverage in Mississippi to increase. The cyclical nature of the insurance market clearly was a major contributing cause of the problems experienced in Mississippi. As investment income decreased, insurers raised rates and tightened their underwriting criteria. In addition, St. Paul and Reciprocal of Virginia, two of the largest insurers in the Mississippi market which conducted only a fraction of their business in Mississippi, exited the market or became insolvent, thereby drastically reducing competition and further increasing rates.[313] Although all insurers were affected by decreased investment gain, MACM, which invests a relatively large percentage of its assets and all of its surplus in the stock market, was substantially impacted by the lagging market. The decline in MACM's investment gain was a major factor contributing to the decline in its income. Moreover, MAMC's surplus was drastically reduced by the end of 2002, in large part due to MACM's $9 million capital loss. MACM was forced to stop selling new policies, thereby further exacerbating the crisis. In addition, all insurers faced increased reinsurance costs in the wake of the September 11, 2001 terrorist attacks. Thus, it is clear that many factors other than the state's civil justice system contributed to the crisis.

Although increasing claim frequency and claim severity may have caused insurers to raise rates, current data indicates that paid losses are decreasing rather than increasing. From 2001 to 2003, MACM's gross paid losses decreased by

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[313] Although this examination of data revealed no evidence supporting the theory that Mississippi rate increases were caused by collusion among insurers, it is certainly plausible that in the absence of competition within Mississippi, insurers, particularly non-admitted surplus lines, sold coverage at non-competitive prices.

more than twenty-six percent, declining from more than $19 million to less than $14 million. This decrease is consistent with the NPDB data indicating that the total amount paid on behalf of Mississippi physicians decreased from more than $40 million in 2001 to just under $30.6 million in 2003. In addition, the number of Mississippi physician payments reported to the NPDB decreased by twenty-three percent from 2001 to 2003. Thus, the data indicates that the number of payments and the total amount paid have decreased substantially since 2001.

Moreover, to the extent that increasing claim frequency and severity caused insurers to raise rates, the Mississippi Legislature responded in 2002 by enacting the MMTRL and the GTRL, which contained numerous substantial reforms, particularly the $500,000 cap on noneconomic damages and the severe limitation on joint and several liability. In addition to these legislative reforms, the Mississippi Supreme Court has severely limited joinder of medical malpractice claims in mass tort litigation, adopted the *Daubert* standard for admission of expert testimony, amended the procedural rules governing venue, joinder and consolidation, and issued recent opinions reversing judgments in favor of medical malpractice plaintiffs, thereby signaling to many that the current court is more favorable to defense challenges than it had previously been.

In light of these substantial legislative and judicial reforms, the legislature should carefully consider whether tort reform legislation which goes beyond the 2002 tort reform legislation is necessary. Prior to enacting a lower cap on noneconomic damages, the legislature should first assure itself that the $500,000 cap is too high and that a $250,000 cap will result in substantial additional benefit.[314] Given that few payments have been made in cases to which the MMTRL applies, it is difficult to know the full effect such legislation will have. It has been suggested by some that the cap will not af-

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[314] In a recent study, the GAO found evidence indicating that caps ranging from $350,000 to $500,000 were as effective as $250,000 caps. IMPLICATIONS, *supra* note 27, at 33.

fect rates until the constitutionality of the cap has been upheld.[315] While that may be true to some extent, it is certainly not a reason to enact even more tort reform given that any additional tort reform would also be subject to constitutional scrutiny.[316] Moreover, in Texas, where voters approved a constitutional amendment authorizing a $250,000 cap on a physician's liability for noneconomic damages, insurers have recently requested substantial rate increases, indicating that factors other than high noneconomic damages are driving rates up.[317]

Considering the data indicating a substantial decrease in total paid losses in 2003, as well as a significant decline in the number of physician payments in 2003, there is not sufficient evidentiary support for lowering Mississippi's cap on noneconomic damages from $500,000 to $250,000, particularly since the evidence also indicates that, recently, insurers have substantially raised rates in some states which capped economic damages at $250,000 years ago. It is far from clear that

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[315] *See, e.g.*, Patrice Sawyer, *Coverage Elusive for Miss. Doctors*, CLARION-LEDGER (Jackson, Miss.), Sept. 17, 2003, at A1.

[316] It is beyond the scope of this Article to examine whether caps on noneconomic damages violate Mississippi's constitution. Although numerous jurisdictions have found caps unconstitutional, many others have upheld the constitutionality of caps. Appendix C includes a brief discussion of the manner in which various jurisdictions have resolved the issue of whether caps are constitutional. The Appendix is meant to be demonstrative rather than exhaustive.

[317] Texas voters passed Proposition 12 in September of 2003 thereby amending the state's constitution to authorize caps on noneconomic damages. Armando Villafranca, *Prop. 12 Winners See Relief for Doctors*, HOUSTON CHRONICLE, Sept. 15, 2003, at 1. A Texas physician's liability for noneconomic damages is limited to $250,000. TEX. CIV. PRAC. & REM. § 74.301 (Vernon 2004). Even though the $250,000 cap is constitutional, insurers have requested rate increases as high as thirty-five percent. One insurer requested a nineteen percent rate increase, arguing that the "cap on damages will actually save it very little money." David Pasztor, *For Most Doctors, Premiums Not Dropping*, AUSTIN-AMERICAN STATEMAN (Texas), Jan. 25, 2004, at B1. In addition to evidence that insurers raise rates after tort reform has passed, there is also evidence that insurers are not lured to enter the market in states which have enacted tort reform. *2003 Survey Shows Rates Still on the Rise, Underwriting Tougher, No End in Sight*, MED. LIABILITY MONITOR, Oct. 2003, at 3 ("Despite recent reform legislation in Florida and Texas, companies continue to retreat from both states. Several companies were asked if they would consider expanding into Florida and Texas since tort reform has been passed, and none responded that they would.").

any additional benefit which might be realized from the imposition of a lower cap is substantial enough to warrant further limitation on patients' recovery of actual damages.

In addition to the inadequate evidence supporting the enactment of a $250,000 cap on noneconomic damages, there is also inadequate evidence supporting legislation that would require all medical malpractice cases to be screened by an independent review panel. Although the objective data reviewed in this article reveals little information indicating whether mandatory screening panels would decrease claim severity or claim frequency, there are clear reasons to be apprehensive about mandatory panels. The use of medical review panels is likely to cause complaining patients to question whether physicians are likely to carefully review their peers, especially when those physicians are aware that any settlement or judgment in any medical malpractice case has the potential to affect the malpractice insurance market.[318] The legislature should consider the recent experience in other states where it appears panels have not worked as intended and have raised costs and delayed resolution of cases. For example, in Louisiana, one insurer contends that the use of medical review panels has increased, rather than decreased, costs.[319] It also appears that claim frequency continues to be

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[318] This would be particularly true, for example, if physicians on the panel were insured by MACM and were reviewing cases against physicians insured by MACM. Not only would the panel physicians have a direct economic stake in the outcome of the case given their equity ownership of MACM, but, presumably, in today's climate, such panel physicians would naturally be biased against any medical malpractice case which might affect the entire medical malpractice liability insurance market.

[319] LAMMICO, *From the CEO: Update on Managing Defense Costs, Effective Expense Management, and Retention of Panel*, THE LETTER, Mar. 12, 2004, *available at* http://www.lammico.com/letter/addendumdetail.asp?addendum=18 (last visited April 13, 2004).

> Although the original intent of the [mandatory review panel] was to provide a medical opinion for the plaintiff with peer review for the physician, in reality the process has become a mini-trial – with all of the associated costs. Because the panel decision is evidentiary, . . . the process has become adversarial and protracted, averaging 22 months to completion.

an issue in Louisiana even though medical review panels have been used for some time.[320] In Arizona, the Legislature repealed the medical review panel after a majority of surveyed medical malpractice attorneys indicated that the panels did not serve the purpose for which they were intended, prolonged litigation and multiplied costs.[321] Several researchers have conducted studies and concluded that medical review panels are not successful in achieving their goals.[322] Moreover, as the information from *Medical Liability Monitor* indicates, insurers in Louisiana have implemented substantial rate hikes in recent years despite the use of medical review panels. In addition to these concerns, there are legitimate concerns that medical review panels violate various constitutional rights, including the right to a jury trial.[323] Given the evidence that

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Id. LAMMICO actually favors amending the legislation so that the panel's decision can no longer be introduced as evidence at trial. *Id.*

[320] LAMMICO, *Controlling the Medical Malpractice Crisis: A Letter from the CEO*, THE LETTER, Jan. 7, 2004, *available at* http://www.lammico.com/letter/addendum-detail.asp?addendum=17 (last visited Apr. 13, 2004) (noting that the frequency of claims in Louisiana is twice that of other states). Also, there is evidence that the number of claims increased from 618 in 1983 to 1077 in 1989 and that the number of open files rose from 81 to 1022, suggesting that Louisiana's mandatory review panel is not curbing growth in the number of claims filed. Jona Goldschmidt, *Where Have All the Panels Gone? A History of the Arizona Medical Liability Review Panel*, 23 ARIZ. ST. L.J. 1013, 1107 (1991).

[321] Goldschmidt, *supra* note 320, at 1041(acknowledging that the dissatisfaction of all involved had been attributed to scheduling problems which unreasonably delayed peer review, reluctance on the part of physicians to judge their peers and the increased costs arising from the added presentation).

[322] PATRICIA MUNCH DANZON, THE INST. FOR CIVIL JUSTICE, THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS 131 (1982) (concluding that analysis failed to show the panels had any effect on the frequency or severity of claims); OFFICE OF TECH. ASSESSMENT, U.S. CONG., IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS 65-68 (1993) (finding that panels tend to increase payments); Goldschmidt, *supra* note 320, at 1107.

[323] The constitutionality of medical review panels is beyond the scope of this article. Several jurisdictions, however, have found them unconstitutional. *See, e.g.*, Boucher v. Sage, 459 A.2d 87 (R.I. 1983) (finding panel in violation of the equal protection clause); Jiron v. Mahlab, 659 P.2d 311 (N.M. 1983) (finding panel in violation of the due process right to access courts without delay); Mattos v. Thompson, 421 A.2d 190 (Pa. 1980) (finding panel in violation of the right to jury trial); Aldana v. Holub, 381 So. 2d 231 (Fla. 1980) (finding panel a violation of due process); Cardinal Glenon Mem'l Hosp. for Children v. Gaertner, 583 S.W.2d 107 (Mo. 1979) (finding panel in violation of the right to access courts).

other states have abandoned such panels and that insurers in Louisiana have had to substantially raise rates and are currently in favor of altering the medical review panel process by making panel decisions inadmissible at trial, the legislature should carefully consider any proposal which mandates screening by a medical review panel.

Although the evidence reviewed in this article does not support the enactment of medical malpractice reform which goes beyond the MMTRL and the GTRL, it does suggest that other legislative and non-legislative responses might help remedy the current situation. First, in light of the data indicating the extent to which MACM's income and surplus have been impacted by the volatility in the stock market, the Mississippi Legislature should consider whether a statutory limitation on the investments made by MACM would decrease the fluctuation in MACM's income and surplus. Given MACM's critical importance to Mississippi's health care system, it is arguable that MACM should not be investing 100% of its surplus in the stock market. A limitation on MACM's investments would probably decrease the overall fluctuation in MACM's profits and surplus, thereby providing more stability to its insureds. At the very least, this issue warrants further study and consideration. Second, in light of the data indicating that relatively few physicians are responsible for the majority of malpractice payments, the Mississippi State Board of Medical Licensure should consider more closely monitoring and reviewing health care providers who have past claims experience and should also encourage greater risk management. Third, in light of that same data, insurers may want to consider placing a greater emphasis on each physician's individual claims experience when calculating rates. Fourth, given that it is extremely difficult to obtain current objective data, the legislature and/or the Mississippi Department of Insurance might want to consider requiring insurers to report more detailed information concerning claim frequency, claim severity and, to the extent possible, the amount of payments made for noneconomic versus economic damages. Such reporting requirements would facilitate evaluation of the medical malpractice insurance market as well as evaluation of enacted and proposed legislative

responses to the present crisis or future crises. In conclusion, based on an evaluation of the substantial statutory reform enacted in 2002, the recent judicial reforms, as well as current objective data concerning the medical malpractice market within Mississippi, there is insufficient evidence to support enacting medical malpractice tort reform which goes beyond the 2002 legislation. In particular, there is little evidence that enacting a $250,000 cap on noneconomic damages or a mandatory medical review panel would reap benefits substantial enough to warrant the imposition of such reforms.

APPENDIX A

EXPLANATION OF HOW OVERESTIMATION OF INCURRED LOSSES AND LOSS EXPENSES DISTORTS INCOME

In order to establish its reserves, an insurer must calculate the losses and loss expenses it expects to incur as the result of policies for which premiums were earned during the accounting year. If an insurer overestimates its losses incurred and loss adjustment expenses (LAE) incurred, it will establish reserves that are larger than necessary.[324] As the losses and LAE develop at amounts below those predicted, the insurer will have to release reserves. This overestimation has the effect of artificially decreasing income in the year in which the premiums were earned and the overestimation made, and artificially increasing income in the year in which the reserves are released.

Formula A1. Underwriting Profit

Underwriting Profit	=	Net Premiums Earned	-	Incurred Losses	-	Incurred LAE	-	Incurred Operating Expenses

To calculate underwriting profit, an insurer must deduct its incurred losses, LAE and operating expenses from net premiums earned. An insurer's incurred losses include all losses actually paid during the accounting year, whether paid pursuant to older policies or policies issued during the accounting year, and any net changes in its total loss reserves from the end of the previous year to the end of the accounting year.

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[324] As was discussed *supra* at text accompanying notes 43-53 and text accompanying notes 224-26, overestimation of incurred losses and loss expenses not only distorts the insurer's financial condition, it can also lead to unwarranted rate increases because the overestimation causes the insurer's loss and loss expense experience to appear worse than it actually is.

Formula A2. Incurred Losses

Incurred Losses for 2003	=	Losses Paid in 2003	+	Net Change in Loss Reserves From 2002 to 2003

Similarly, an insurer's incurred LAE includes the LAE actually paid during the accounting year and any net change in its LAE reserves.

Formula A3. Incurred LAE

Incurred LAE for 2003	=	LAE Paid in 2003	+	Net Change in LAE Reserves From 2002 to 2003

To demonstrate the manner in which overestimation of incurred losses and loss expenses distorts income, assume that ABC Insurance Co. is a medical malpractice insurer which sells claims-made policies. As Table A1 demonstrates, assume ABC actually paid $225,000 in losses and LAE in 2003 as the result of policies issued from 2000 to 2003.

Table A1. ABC Insurance Company (Accurate Reserves)

Year	Loss and LAE Payments in 2003	2002 Loss and LAE Reserves	2003 Loss and LAE Reserves
2000	90,000	100,000	10,000
2001	75,000	150,000	75,000
2002	50,000	200,000	150,000
2003	10,000		215,000
Total	225,000	450,000	450,000

Thus, in 2003, ABC would report $225,000 in losses and LAE incurred because ABC's $450,000 loss and LAE reserves reported at the end of 2003 were the same as those reported at the end of 2002. Given that ABC made no adjustments to its reserves for previous years, the $225,000 deduction for incurred losses and LAE in 2003 equals the total estimated losses and LAE ABC expects to pay as the result of policies sold in 2003.[325]

Assume, instead, that ABC overestimated its incurred losses and LAE arising from claims made in 2000 by $10,000, from claims made in 2001 by $15,000 and from claims made in 2002 by $20,000 and that ABC corrects this overestimation in 2003. As demonstrated in Table A2, ABC must decrease its existing reserves by $45,000. ABC's loss and LAE reserves at the end of 2003 will only total $405,000. Thus, in 2003, ABC would report incurred losses and LAE of only $180,000 (the $225,000 it actually paid in 2003 plus the $45,000 decrease in its reserves from 2002 to 2003). Given that in 2003, ABC will only deduct $180,000 in incurred losses and LAE from its net premiums earned, ABC's net income for 2003 will be $45,000 higher than it would have been had it accurately established its reserves for policy years 2000 to 2002.

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[325] ABC paid $10,000 on 2003 policies in 2003 and established a reserve of $215,000.

Table A2. ABC Insurance Company (Reserve Release Due to Overestimation)

Year	Loss and LAE Payments in 2003	2002 Loss and LAE Reserves	2003 Loss and LAE Reserves
2000	90,000	100,000	0
2001	75,000	150,000	60,000
2002	50,000	200,000	130,000
2003	10,000		215,000
Total	225,000	450,000	405,000

ABC's overestimation of its reserves in the years 2000 to 2002 caused its income in those years to be understated because the overestimation led to a greater deduction for incurred losses and LAE. Correspondingly, ABC's 2003 correction of its earlier overestimation results in a net income for 2003 that does not accurately portray the profit ABC is expected to earn from coverage it provided in 2003. ABC's 2003 income was artificially increased by the $45,000 it released from its reserves.

APPENDIX B

TABLE B1. NPDB/MISSISSIPPI MILLION DOLLAR PAYMENTS[326]

Year of Record	Payment	Type of Claim
1992	$ 995,000	Surgery - Improper Management of Surgical Patient
1992	$ 995,000	Surgery - Improper Management of Surgical Patient
1995*	$4,950,000	Diagnosis - Failure to Diagnose
1999	$4,950,000	Surgery - Improper Performance of Surgery
1997	$ 995,000	Diagnosis
1997**	$ 995,000	Obstetrics - Improperly Performed Vaginal Delivery
1997	$2,950,000	Diagnosis - Failure to Diagnose
1997	$3,050,000	Monitoring - Failure to Report on Patient Condition
1997	$3,650,000	Obstetrics - Delay in Delivery: Induction or Surgery
1997	$1,450,000	Obstetrics - Improperly Performed Vaginal Delivery
1999	$ 995,000	Diagnosis - Failure to Diagnose
1999	$ 995,000	Diagnosis - Failure to Diagnose
1999	$ 995,000	Treatment
1999	$ 995,000	Diagnosis
1999	$ 995,000	Diagnosis
1999	$ 995,000	Surgery - Improper Performance of Surgery
1999	$ 995,000	Treatment - Failure to Treat
1999	$ 995,000	Diagnosis - Failure to Diagnose
1999	$ 995,000	Diagnosis

[326] *See* U.S. Dep't of Health and Human Servs., *supra* note 247. The NPDB codes payments between $990,000 and $1,000,000 as payments for $995,000. Thus, all reports of payments for $995,000 have been included because they may represent actual payments of $1,000,000.

* The reports for these payments did not indicate whether the payments were made to satisfy a judgment or pursuant to a settlement agreement.

** These payments were to satisfy a judgment. Payments by which there is no asterisk were payments made as part of settlement.

1999	$1,950,000	Diagnosis - Failure to Diagnose
1999	$1,950,000	Diagnosis - Failure to Diagnose
1999	$1,250,000	Diagnosis - Delay in Diagnosis
2000	$ 995,000	Diagnosis - Failure to Diagnose
2000*	$1,150,000	Diagnosis
2001	$1,2500,00	Surgery
2001	$ 995,000	Surgery
2001	$ 995,000	Surgery
2001	$ 995,000	Treatment - Failure to Treat
2001	$ 995,000	Diagnosis - Wrong Diagnosis or Misdiagnosis
2001	$1,450,000	Medication - Improper Management of Medication Regimen
2001**	$1,450,000	Diagnosis - Failure to Diagnose
2001	$ 995,000	Medication - Wrong Dosage Ordered of Correct Medication
2001	$ 995,000	Treatment
2001	$ 995,000	Medication - Medication Administration Related
2002*	$ 995,000	Anesthesia
2002	$ 995,000	Obstetrics - Failure to Manage Pregnancy
2002	$2,450,000	Obstetrics - Improper Choice of Delivery Method
2002	$ 995,000	Surgery - Improper Performance of Surgery
2002	$ 995,000	Diagnosis - Delay in Diagnosis
2002	$ 995,000	Diagnosis - Failure to Diagnose
2003	$ 995,000	Obstetrics - Improper Choice of Delivery Method
2003	$ 995,000	Surgery - Improper Performance of Surgery
2003	$1,050,000	Diagnosis - Failure to Diagnose
2003	$ 995,000	Surgery - Unnecessary Surgery
2003	$1,450,000	Anesthesia - Failure to Monitor
2003	$ 995,000	Diagnosis - Delay in Diagnosis

Appendix C

Summary of Cases Addressing Constitutionality of Damage Caps

Equal Protection

Several courts have held that caps on noneconomic damages are in violation of their state's equal protection clause. The Alabama Supreme Court stated that placing a cap on damages "creates a favored class of tort-feasors, based solely upon their connection with health care, . . . favored subclasses within the favored class by shielding those health care providers whose actions are the most egregious," and "classifications based upon the severity of the injury." Moore v. Mobile Infirmary Ass'n, 592 So.2d 156, 166-67 (Ala. 1991); *see also* Carson v. Maurer, 424 A.2d 825, 940-41 (N.H. 1980) (holding that the damages cap discriminates in favor of the class of health care providers). *But see* Evans *ex rel.* Kutch v. State, 56 P.3d 1046, 1052-55 (Alaska 2002) (noting the legitimate state interest of the tort reform objectives in applying a "sliding scale" test to determine constitutionality); Fein v. Parmanente Med. Group, 695 P.2d 665, 682 (Cal. 1985) (holding statutory cap constitutional because it was fair, reasonable and rationally related to the legislative purpose—remedying the insurance crisis); Scholz v. Metropolitan Pathologists, P.C., 851 P.2d 901, 906 (Colo. 1993) (same); Jones v. State Bd. of Med., 555 P.2d 399, 411-12 (Idaho 1976) (same); Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585, 597 (Ind. 1980) (holding statutory cap to be reasonable, not arbitrary, and for the purpose of the protection of the health of the state's citizens); Butler v. Flint Goodrich Hosp., 607 So.2d 517, 519-21 (La. 1992) (same); Murphy v. Edmonds, 601 A.2d 102, 114-16 (Md. 1992) (same); Zdrojewski v. Murphy, 657 N.W.2d 721, 738-39 (Mich. 2002) (same); Adams v. Children's Mercy Hosp., 832 S.W.2d 898, 903-05 (Mo. 1992) (same); Prendergast v. Nelson, 256 N.W.2d 657, 667 (Neb. 1977) (same); Morris v. Svoy, 576 N.E.2d 765, 771-72 (Ohio 1991) (holding statutory cap to be constitutional on equal protection grounds, but unconstitutional on due process grounds); Greist v. Phillips, 906 P.2d 789, 798-800 (Or. 1995)

(stating that recovery of damages is not a fundamental right and that the legislature had a rational basis for imposing the limit); Etheridge v. Med. Ctr. Hosps., 376 S.E.2d 525, 534 (Va. 1989) (finding statutory cap to be a reasonable and non-arbitrary solution to a legitimate state interest); Robinson v. Charleston Area Med. Ctr., 414 S.E.2d 877, 883 (W.Va. 1991) (validating the statutory cap and holding that "[w]here economic rights are concerned, we look to see whether the classification is a rational one based on social, economic, historic or geographic factors, whether it bears a reasonable relationship to a proper governmental purpose, and whether all persons within the class are treated equally"); Guzman v. St. Francis Hosp., Inc., 623 N.W.2d 776, 788 (Wis. 2000) (holding that statute was not "patently arbitrary" and bears a rational relationship to the legitimate government interest).

Jury Trial

In some states, courts have interpreted their constitutional provisions as saying that the jury's role in a civil trial includes the calculation of damages, stating that the measure of damages is one of the questions of fact to be answered by the jury. Sofie v. Fibreboard Corp., 771 P.2d 711, 716 (Wash. 1989). Because statutory caps on noneconomic damages limit the jury's right to determine damages, the Washington Supreme Court found the statute to be unconstitutional. *Id.* at 717; *see also* Moore v. Mobile Infirmary Ass'n, 592 So.2d 156, 159-62 (Ala. 1991) (holding that, based on the Alabama Constitutional provision that the right to a jury trial shall remain "inviolate," jury determination of damages is crucial—"particularly sacrosanct in cases involving damages not susceptible of precise measurement"); Smith v. Dep't of Ins., 507 So.2d 1080, 1088-89 (Fla. 1987) (same).

However, some courts have held that placing a statutory cap on noneconomic damages does not violate their states' constitutional right to a jury trial. In *Samsel v. Wheeler Transport Services, Inc.*, the Kansas Supreme Court noted that the common law right to a jury trial may be modified by statute as long as the statute meets "due process requirements and [is] reasonably necessary in the public interest to promote the

general welfare of the people of the state." 789 P.2d 541, 555-56 (Kan. 1990). In order to meet due process requirements, there must be a quid pro quo remedy in return for there being no jury trial. In this case, the court held that the quid pro quo was that there would be no remittitur if the jury verdict was less than the statutory cap. *Id.* at 557-58. In many states' constitutions, the right to a jury trial is protected only to the extent that the right existed at common law. *Id.*; *see also* Evans *ex rel.* Kutch v. State, 56 P.3d 1046, 1051 (Alaska 2002) (holding that the statutory cap "did not intrude on the jury's fact-finding function, because the cap was a 'policy decision' applied after the jury's determination, and did not constitute a re-examination of the factual question of damages"); Scholz v. Metropolitan Pathologists, P.C., 851 P.2d 901, 905-06 (Colo. 1993) (holding that Colorado Constitution provides an absolute right to jury trial in criminal cases, but not civil cases); Kirkland v. Blaine County Med. Ctr., 4 P.3d 1115, 1119 (Idaho 2000) (holding that, although a common law right to jury trial exists, the legislature has the power to regulate remedies for certain causes of action); Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585, 602 (Ind. 1980) (comparing the legislative right to take away trial by jury with that of imposing statutes of limitations); Murphy v. Edmonds, 601 A.2d 102, 116-17 (Md. 1992) (stating that a jury issue never arises when legislative abrogation occurs); Gourley *ex rel.* Gourley v. Nebraska Methodist Health Sys., Inc., 663 N.W.2d 43, 75 (Neb. 2003) (holding that a remedy is a question of law, not fact, and is therefore not protected by the constitutional provision protecting trial by jury); Lakin v. Senco Products, Inc., 987 P.2d 463, 475 (Or. 1999) (holding that the jury's fact-finding right—the assessment of damages—may not be abrogated by legislation); Etheridge v. Med. Ctr. Hosps., 376 S.E.2d 525, 529 (Va. 1989) (stating that remedy is a matter of law, not of fact and that imposing statutory limitation is appropriate after jury has ascertained facts and assessed damages); Robinson v. Charleston Area Med. Ctr., 414 S.E.2d 877, 887-88 (W.Va. 1991) (stating that legislative imposition of statutory limit does not violate "reexamination" clause of the right to trial by jury); Guzman v. St. Francis Hosp., Inc., 623 N.W.2d 776, 783 (Wis. 2000) (not-

ing legislature's constitutional right to modify the common law).

Access to Courts

Another argument made against statutory caps on damages is that a plaintiff's meaningful access to courts, guaranteed by the due process clause, is violated. At least one court has reasoned that a plaintiff's "right to adequate remedy" is infringed upon by placing a limit on what may be recovered, provided that the remedy existed at common law. Smith v. Dep't of Ins., 507 So.2d 1080, 1088 (Fla. 1987) (holding that, in order for restrictions to be placed on damages, either a reasonable alternative must be given or public necessity for the restriction must be shown such that no other alternative exists).

Some courts reason that the right of access to courts is not violated by a cap on damages because the caps are "not so drastic so as to eliminate the tort remedies that they modify." Evans *ex rel.* Kutch, 56 P.3d 1046, 1056-57 (Alaska 2002) (holding that caps do not impede actual access to courts); *see also* Jones v. State Bd. of Med., 555 P.2d 399, 404-05 (Idaho 1976); Prendergast v. Nelson, 256 N.W.2d 657, 663 (Neb. 1977) (holding that the access to courts clause is merely a general principle which does not mean that the legislature is prohibited from imposing certain procedures); Rose v. Doctors Hosp. 801 S.W.2d 841, 845 (Tex. 1990) (stating that the constitutional right of access to courts applies only to common law remedies, not to statutorily created remedies such as wrongful death claims).

Due Process

In at least one state, the court has held that no proof exists as to the effect of a damages cap on the public welfare. Morris v. Savoy, 576 N.E.2d 765, 770-71 (Ohio 1991). While most due process claims are dismissed because of the ease in finding a "rational relationship" between the statute and its objective, i.e., public welfare, the Ohio Supreme Court looked for actual proof that the statute was having an effect and found none. *Id.* (finding no evidence that damages cap would

realistically lower medical malpractice insurance and therefore finding no rational relationship between the statute and public welfare). *But see* Evans *ex rel.* Kutch v. State, 56 P.3d 1046, 1055 (Alaska 2002) (finding damages cap constitutional by noting that substantive due process test is similar but even more deferential than equal protection test, under which statute was held constitutional); Fein v. Permanente Med. Group, 695 P.2d 665, 680 (Cal. 1985) (holding that the statutory damages cap is rationally related to the objective of reducing costs of malpractice claims); Scholz v. Metro. Pathologists, P.C., 851 P.2d 901, 907 (Col. 1993) (noting that no deprivation of property without hearing occurred because plaintiffs have no property interests in remedies); Jones v. State Bd. of Med., 555 P.2d 399, 406-07 (Idaho 1976) (upholding damages statute based on the rational relationship to the promotion of public welfare); Johnson v. St. Vincent Hosp., Inc. 404 N.E.2d 585, 598-99 (Ind. 1980) (same); Samsel v. Wheeler Transport Servs., Inc., 789 P.2d 541, 557-58 (Kan. 1990) (upholding statute under claim of due process violation because the damages award under the statutory cap would not be remitted); Univ. of Md. Med. Sys. Corp. v. Malory, 795 A.2d 107, 123 (Md. App. 2001) (stating that a jury verdict does not qualify as property for purposes of the takings clause); Prendergast v. Nelson, 256 N.W.2d 657, 667 (Neb. 1977) (holding that state interest of maintaining reasonable medical costs invalidates claim of due process violation); Etheridge v. Med. Ctr. Hosps., 376 S.E.2d 525, 531 (Va. 1989) (giving wide deference to statutes that are economic regulations); Robinson v. Charleston Area Med. Ctr., 414 S.E.2d 877, 887 (W.Va. 1991) (same); Guzman v. St. Francis Hosp., Inc., 623 N.W.2d 776, 789-90 (Wis. 2000) (same).

Separation of Powers

Several courts have addressed the claim that a statutory cap on damages violates the separation of the judicial and legislative branches of government. Specifically, claims have been made that a damages cap constitutes a legislative remittitur whereby the legislature unconstitutionally takes over the duties of the judiciary. *See* Best v. Taylor Machine Works, 689 N.E.2d 1057, 1080 (Ill. 1997). (holding that a cap on

noneconomic damages "undercuts the power, and obligation, of the judiciary to reduce excessive verdicts" by disregarding a jury's deliberative process); *see also* Sofie v. Fibreboard Corp., 771 P.2d 711, 720-21 (Wash. 1989) (noting that a mandatory damages cap changes the outcome of a jury trial, which should only be changed by the judiciary, on a case-by-case basis). *But see* Evans *ex rel.* Kutch v. State, 56 P.3d 1046, 1055-56 (Alaska 2002) (holding that damages cap necessarily falls under the legislative power because modification and abolition of common law includes the power to set limits on recovery); Kirkland v. Blaine County Med. Ctr., 4 P.3d 1115, 1122 (Idaho 2000) (same); Zdrojewski v. Murphy, 657 N.W.2d 721, 739 (Mich. App. 2002) (holding that, since the damages cap statute is substantive rather than procedural law, legislature has the power to change it without infringing on the judiciary); Etheridge v. Med. Ctr. Hosps., 376 S.E.2d 525, 532 (Va. 1989) (stating that the legislature is within its power in setting a damages cap because they have the power to "provide, modify, or repeal a remedy"); Robinson v. Charleston Area Med. Ctr., 414 S.E.2d 877, 879 (W.Va. 1991) (noting the presumption that legislation is constitutional); Guzman v. St. Francis Hosp., Inc., 623 N.W.2d 776, 785-86 (Wis. 2000) (same).

Special Legislation

In Illinois, the Supreme Court has held that the cap on noneconomic damages violates the "certain remedy" clause, which prohibits the legislature from "conferring a special benefit or exclusive privilege on a person or a group of persons to the exclusion of others similarly situated." Best v. Taylor Mach. Works, 689 N.E.2d 1057, 1069 (Ill. 1997). Using a standard similar to that for an equal protection challenge, the court determined that the statutory cap on damages unfairly favored certain tortfeasors (the ones who would have been liable for more than the capped damages amount). *Id.* Additionally, that court determined that the difficulty in determining the value of noneconomic damages should not be overcome by having an arbitrary damages cap. *Id.* at 1076. The court also stated that there was no rational relationship between the cap and the legislative interest in lowering tort liability costs as a whole

because the cap applied only to one type of damages of one class of plaintiffs. *Id.* at 1077. *But see* Evans *ex rel.* Kutch v. State, 6 P.3d 1046, 1057 (Alaska 2002) (stating, without discussion, that the special legislation claim failed for the same reasons as the equal protection claim); Kirkland v. Blaine County Med. Ctr., 4 P.3d 1115, 1121-22 (Idaho 2000) (holding that damages cap was not an arbitrary or unreasonable means for state interest of protecting availability of liability insurance); Univ. of Md. v. Malory, 795 A.2d 107, 122-23 (Md. App. 2001) (stating that damages cap that applied to any action for personal injury did not constitute special legislation); Gourley *ex rel.* Gourley v. Neb. Methodist Health Sys., Inc., 663 N.W.2d 43, 66-69 (Neb. 2003) (noting the difference between equal protection analysis and special legislation analysis and holding that, though some inequality may exist under damages cap statute, deference must be given); Etheridge v. Med. Ctr. Hosps., 376 S.E.2d 525, 533 (Va. 1989) (holding that legislation's interest of keeping insurance costs down was a legitimate state interest).

APPENDIX D

SUMMARY OF AND REMARKS ABOUT HOUSE BILL 13

On June 16, 2004, Governor Barbour signed House Bill 13, which contains a few tort reform provisions specifically applicable to medical malpractice cases and several tort reform provisions applicable to all civil cases, including medical malpractice cases.[327] House Bill 13 limits venue in medical malpractice cases to the county in which the alleged act or omission occurred.[328] Venue is no longer appropriate in the defendant's county of residence or, in wrongful death cases, in the county in which the death occurred, unless that is also where the defendant allegedly committed negligence.[329] Given that the GTRL had already limited venue to the county in which the defendant resided, the county in which the alleged act or omission occurred or the county where the event that caused the injury occurred, it is unlikely that the additional venue limitations contained in House Bill 13 will have much impact on the medical malpractice insurance market, particularly since many physicians reside and practice within the same county.[330]

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[327] Act of June 16, 2004, ch. 1, 2004 Miss. Laws ____ (to be codified at various sections in the Mississippi Code).

[328] *Id.* § 1 (to be codified at MISS. CODE ANN. § 11-11-3(3)). This provision may be problematic in medical malpractice cases involving multiple defendants who committed negligence in different counties. In such circumstances, the plaintiff should be able to sue the joint tortfeasors in one action. For example, a patient may be negligently treated by a physician in one county and then, for the same illness, be negligently treated by a hospital in another county. For economic and efficiency concerns, that patient should be able to sue the physician and the hospital in the same lawsuit.

[329] For a discussion of the venue provisions applicable prior to the passage of House Bill 13, see *supra* notes 150-53 and accompanying text.

[330] House Bill 13 codified the newly amended Rule 82(e) of the Mississippi Rules of Civil Procedure, which authorized intrastate transferal of cases based on the doctrine of forum noncoveniens. House Bill 13 also contains an interstate forum nonconveniens provision authorizing courts to dismiss an action if they find that the action would more properly be heard outside the state. Act of June 16, 2004, ch. 1, § 1 (to be codified at MISS. CODE ANN. § 11-11-3(4)). House Bill 13 also limits plaintiffs' choice of venue in cases against nonresident defendants, authorizing venue in the plaintiff's county of residence only as a last resort. *Id.*

House Bill 13 also contains a provision requiring each plaintiff to independently establish proper venue.[331] Arguably, in the medical malpractice context, this provision is unnecessary and will have little impact because the Mississippi Supreme Court, in *Janssen*, severely limited the joinder of medical malpractice claims, thereby limiting joinder as a method of establishing venue. The provision directly contradicts Mississippi Rule of Civil Procedure 82(c), which provides that when several claims have been joined, venue is appropriate in any county where any single claim could have been brought.[332]

House Bill 13 removed the language from the MMTRL that would have automatically increased the $500,000 cap on noneconomic damages in medical malpractice cases to $750,000 in 2011, and to $1 million in 2017.[333] Pursuant to House Bill 13, the cap on noneconomic damages will remain at $500,000. The elimination of the cap increase is unlikely to affect current malpractice rates, given that the $500,000 cap had already been in effect and was to remain in effect through mid-2011. Whether removal of the cap increase will provide some future benefit is difficult to predict, given that numerous factors affect the insurance market. Although some adjustment to the cap increases may have been necessary, there was no evidentiary basis for simply eliminating the cap increase altogether.[334] In many jurisdictions, caps are periodically in-

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§ 1 (to be codified at MISS. CODE ANN. § 11-11-3(1)). These provisions will likely have little impact on medical malpratice cases.

[331] *Id.* (to be codified at MISS. CODE ANN. § 11-11-3(2)).

[332] This statutory provision raises the constitutional question whether the legislature violated the separation of power by encroaching on the Mississippi Supreme Court's authority to promulgate procedural rules. Rule 82(b) implies that venue provisions in Rule 82 have priority over statutory provisions. Moreover, the Mississippi Supreme Court has held that its "rulemaking power is a function of our constitution's command that the three great governmental powers be separate." Hall v. State, 539 So. 2d 1338, 1345 (Miss. 1989).

[333] Act of June 16, 2004, ch. 1, § 2 (to be codified at MISS. CODE ANN. § 11-1-60(1)(a)). For a discussion of the cap increase pursuant to the MMTRL, see *supra* note 125 and accompanying text.

[334] Some adjustment may have been necessary because, under the MMTRL, the higher caps applied to cases filed on or after a certain date, thereby giving plaintiffs the incentive to wait until that date, if possible, to file a complaint.

creased by small increments which are sometimes based on inflation.[335] Absent evidence indicating that inflation-based adjustments or small annual increases render caps ineffective, the legislature should have included some type of periodic adjustment to the $500,000 cap.

House Bill 13 redefined "noneconomic damages" to include damages for "disfigurement."[336] Damages for disfigurement had been excepted from noneconomic damages under the MMTRL.[337] House Bill 13 also removed language in the MMTRL which had exempted cases warranting punitive damages from the cap.[338] As a result, there are no exceptions to the $500,000 cap on noneconomic damages. Other jurisdictions which have established damage caps have excepted cases in which the defendant's conduct is more egregious than basic negligence or cases where the plaintiff's noneconomic damages are likely to be permanent and severe.[339] The data reviewed in this article indicating that the total number of physician

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For example, the $750,000 cap would have applied to cases filed on or after July 1, 2011, thereby giving plaintiffs having claims accruing on or after July 1, 2009 a strong incentive to file their complaints on or after July 1, 2011, which may have greatly skewed the number of claims filed in late 2011 and early 2012, thereby making insurance for that period difficult to price. Act of Oct. 8, 2002, ch. 2, 2002 Miss. Laws 1274, § 7(2) (codified at MISS. CODE ANN. § 11-1-60(2)). This potential problem, however, could have been cured by simply increasing the cap by smaller increments every year or by making any cap increases applicable to cases which occur or accrue after a certain date, thereby removing a plaintiff's ability to manipulate application of the cap increase.

[335] *See, e.g.,* MD. CODE ANN., CTS. & JUD. PROC. § 11-108(b)(2)(ii) (2002) (increasing the cap by $15,000 each year); MO. ANN. STAT. § 538.210 (West 2002) (tying the annual increase or decrease in the cap to the Implicit Price Deflator for Personal Consumption Expenditures); UTAH CODE ANN. § 78-14-7.1(2) (2002) (raising the cap based on inflation).

[336] Act of June 16, 2004, ch. 1, § 2 (to be codified at MISS. CODE ANN. § 11-1-60).

[337] Act of Oct. 8, 2002, ch. 2, § 7(1)(a); *see also supra* note 125.

[338] Under the MMTRL, the cap does not apply to cases in which the judge determines that the jury could appropriately award punitive damages. Act of Oct. 8, 2002, ch. 2, § 7(3). Under House Bill 13, there are no exceptions to the application of the $500,000 cap. Thus, if a doctor were to commit negligence while under the influence of alcohol or illegal drugs, the cap would still apply.

[339] *See, e.g.,* ALASKA STAT. § 09.17.010(c) (Michie 2002) (excepting cases of severe permanent physical impairment or severe disfigurement); IDAHO CODE § 6-1603(4)(a) (Michie 2003) (excepting cases where the defendant was willful or reckless).

payments and the total amount paid on behalf of physicians is decreasing provides no evidentiary basis for the legislature's removal of these narrow exceptions to the cap.[340]

House Bill 13 eliminated the imposition of joint and several liability in all cases unless the defendants "consciously and deliberately pursue a common plan or design to commit a tortuous act, or actively take part in it."[341] Mississippi is now in the minority of jurisdictions which generally impose several liability.[342] Given that the MMTRL and the GTRL had already severely restricted the imposition of joint liability, there is little indication that further restriction of joint liability was necessary or that it will have any noticeable impact on the current medical malpractice market. As discussed in the article, a liability scheme which imposes several liability places all of the risk that any tortfeasor is immune or insolvent on the innocent patient rather than the negligent defendant.[343]

House Bill 13 also lowered some of the caps on punitive damages previously established by the GTRL.[344] For example, a defendant whose net worth is $50 million can now be ordered to pay no more than $1 million in punitive damages.[345] Given that the caps established by the GTRL had been in effect less than eighteen months, there is scant evidence that

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[340] The NPDB data indicates that from 2001 to 2003, the total number of physician payments in Mississippi decreased by twenty-three percent while the amount paid on behalf of Mississippi physicians decreased by twenty-six percent. *See supra* note 249 and accompanying Table 8. The NPDB data for the first quarter of 2004 indicates that, in Mississippi, there were only sixteen physician payments made during those three months. Moreover, the average Mississippi payment was only $213,797, substantially lower than the corresponding national average payment of $316,132 and the 2003 Mississippi average payment of more than $270,000. *See supra* note 248.

[341] Act of June 16, 2004, ch. 1, § 6 (to be codified at MISS. CODE ANN. § 85-5-7).

[342] RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY § 17, at 154 (2000) (listing only sixteen states which impose several liability).

[343] For a more detailed discussion of the various liability schemes, see *supra* note 131.

[344] Act of June 16, 2004, ch. 1, § 4 (to be codified at MISS. CODE ANN. § 11-1-65). The caps were reduced for defendants with a net worth at the low end of the scale established by the GTRL. No revisions were made to the caps for defendants with a net worth at the high end of the scale.

[345] *Id.* § 4 (to be codified at MISS. CODE ANN. § 11-1-65(3)(a)(vi)).

even lower caps were necessary, particularly since a plaintiff must meet such a high evidentiary burden before recovering punitive damages.[346] It is unlikely that these lower punitive damage caps, which serve to protect defendants who have engaged in intentional misconduct or gross negligence, will significantly affect the medical malpractice insurance market, given that punitive damages are almost never imposed in medical malpractice cases.[347]

Although the Mississippi Legislature did not lower the cap on noneconomic damages in medical malpractice cases to $250,000 or mandate screening of malpractice cases by a medical review panel, it did enact tort reform measures, such as the removal of the cap increases and the further restriction of joint and several liability, which place further restrictions on patients' ability to recover actual damages. The additional protection afforded to health care providers by House Bill 13 is not warranted by the evidentiary data reviewed in this article and may have little beneficial impact on the current medical malpractice insurance market.

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[346] MISS. CODE ANN. § 11-1-65(1)(a) (Supp. 2002). A plaintiff must prove by clear and convincing evidence that the defendant acted with actual malice or gross negligence evidencing a willful, wanton or reckless disregard for the safety of others, or committed fraud. *Id.*

[347] In addition to the provisions discussed above, House Bill 13 gives a patient who has filed a complaint with the Mississippi Board of Medical Licensure the right to attend disciplinary proceedings related to the patient's treatment. Act of June 16, 2004, ch. 1, § 16 (to be codified at MISS. CODE ANN. § 73-25-77). House Bill 13 also contains numerous provisions designed to promote and encourage jury duty service. *Id.* § 8-15 (to be codified in various sections of the Mississippi Code). House Bill 13 contains provisions which apply to specific tort claims other than malpractice. For example, House Bill 13 eliminates a property owner's or occupier's liability for the death of an independent contractor or the employee of an independent contractor when the contractor should have known about the danger that caused the death. *Id.* § 5 (to be codified at MISS. CODE ANN. § 11-1-66). Also, even though the GTRL had authorized "innocent" retail sellers to move for dismissal in products liability actions, House Bill 13 now provides that product sellers other than manufacturers cannot be held liable pursuant to MISS. CODE ANN. § 11-1-63 unless the seller exercised control over the aspect of the product which caused the damage, altered the product in a way that contributed to the damage or should have known about the defective condition of the product. *Id.* § 3 (to be codified at MISS. CODE ANN. § 11-1-63(h)).

THE MUTUAL FUND SUMMIT: CONTEXT AND COMMENTARY

Mercer E. Bullard[*]

I. INTRODUCTION

On January 23 and 24, 2004, the University of Mississippi School of Law and Fund Democracy[1] hosted the Mutual Fund Summit in Oxford, Mississippi. The Summit was a seminal event in the history of the mutual fund industry, bringing together for the first time leading industry representatives, academics, shareholder advocates and regulators to discuss in both public and private forums current issues facing the industry. The highlight of the Summit was a public panel discussion on January 24. This article identifies major themes in the panel discussion, places them in context and comments on their policy implications, followed by a verbatim transcript.[2]

The Summit was historic not only for the breadth of views brought together at one event but also for the eventful period in which it was held. The mutual fund industry had reached both a nadir and zenith (a nadith?) in its history. Mutual fund assets, after dropping below $7 trillion during the stock market decline from mid-2000 to 2002,[3] rebounded to a record

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[1] Fund Democracy is an advocacy group for mutual fund shareholders of which this author is the founder and president. The Summit was also sponsored by the Zero Alpha Group, National Association of Personal Financial Advisors and the Financial Planning Association.

[2] The archived webcast of the Mutual Fund Summit is available at http://www.olemiss.edu/webcast/ (last visited on June 15, 2004).

[3] *See* Investment Company Institute, Trends in Mutual Fund Investing: August 2000, *at* http://www.ici.org/stats/mf/arctrends/trends_08_00.html#TopOfPage (last visited June 10, 2004) (stating that total industry assets in August 2000 equaled $7.490 trillion); Investment Company Institute, Trends in Mutual Fund Investing: March 2000, *at* http://www.ici.org/stats/mf/arctrends/trends_03_00.html#TopOfPage (last visited June 10, 2004) (stating that total industry assets at the end of March 2000 equaled $7.294 trillion); Investment Company Institute, 2003 Mutual Fund Fact Book 63, *at* http://www.ici.org/stats/mf/2003_factbook.pdf (last visited June 10, 2004) (listing total industry assets at the end of 2000, 2001 and

$7.6 trillion in February 2004.[4] More than ninety million Americans, representing approximately fifty percent of U.S. households, invest in mutual funds.[5] Mutual funds had only one year of net redemptions from 1990 through 2003 and began 2004 with record inflows.[6]

At the same time that mutual fund assets were nearing historic highs, the reputation of the mutual fund industry was reaching new lows. On September 3, 2003, New York Attorney General Eliot Spitzer filed and settled charges against Canary Capital Partners, LLC (Canary), a hedge fund that allegedly engaged in illegal trading of mutual fund shares.[7] This alone was newsworthy, as Spitzer had recently settled high-profile cases with Wall Street firms relating to investment banking and analyst relationships,[8] and Canary's managing partner

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2002, respectively: $6,964,667.0, $6,974,975.9, and $6,391,570.8).

[4] *See* Investment Company Institute, Trends in Mutual Fund Investing: February 2004, *at* http://www.ici.org/stats/mf/trends_02_04.html#TopOfPage [hereinafter Trends: February 2004] (last visited June 10, 2004).

[5] In October 2003, there were 91.2 million mutual fund investors. *See* Investment Company Institute, *U.S. Household Ownership of Mutual Funds in 2003*, 12 FUNDAMENTALS 2, fig. 2 (Oct. 2003), *available at* http://www.ici.org/stats/res/fm-v12n4.pdf (last visited June 10, 2004). Between 1998 and October 2003, the number of individual investors in mutual funds ranged from 77.7 million to 95.8 million, and the percentage of U.S. households owning mutual funds ranged from 44.0% to 52.0%. *Id.* at 1–2.

[6] Mutual funds had net cash inflows of $22.9 billion, $6.7 billion and $15 billion in January, February and March 2004. John Shipman, *Fund Track*, WALL ST. J., , Apr. 27, 2004, at D9 (reporting Lipper Anaytics data for March 2004); Trends: February 2004, *supra* note 4; Investment Company Institute, Trends in Mutual Fund Investing: January 2004, *at* http://www.ici.org/stats/mf/trends_01_04.html#TopOfPage (last visited June 10, 2004). Mutual funds experienced net outflows in 2003, mainly due to large outflows from money market funds as a result of declining interest rates. *See* Investment Company Institute, *Mutual Fund and Economic Developments in 2003*, 10 PERSPECTIVE 1, 3 (Mar. 2004), *available at* http://www.ici.org/stats/res/per10-01.pdf (last visited June 10, 2004).

[7] *See* New York v. Canary Capital Partners, LLC (N.Y. Sup. Ct. Sept. 3, 2003), *available at* http://www.oag.state.ny.us/press/2003/sep/canary_complaint.pdf; *see also* Press Release, Office of the New York State Attorney General Eliot Spitzer, State Investigation Reveals Mutual Fund Fraud (Sept. 3, 2003), *available at* http://www.oag.state.ny.us/press/2003/sep/ sep03a_03.html (last visited June 10, 2004).

[8] *See, e.g.*, Assurance of Discontinuance, *In re* Citigroup Global Markets, Inc. (Apr. 21, 2003), *available at* http://www.oag.state.ny.us/investors/citigroup/citigroup_aod.pdf); *see also* Press Release, Office of the New York State Attorney General Eliot Spitzer, Conflict Probes Resolved at Citigroup and Morgan-Stanley

was Edward Stern, son of billionaire Leonard Stern.[9] But what was most significant about the *Canary* case was that the mutual funds and their affiliates were not unwitting victims, but knowing participants, in Stern's and Canary's activities. The funds' affiliates negotiated arrangements under which Canary traded the mutual funds' shares, provided access to fund portfolio holdings to facilitate Canary's investment strategy, enabled Canary to illegally trade shares of mutual funds outside of the immediate fund group and even loaned Canary money to finance its trading. Follow-up investigations by Spitzer, the U.S. Securities and Exchange Commission (Commission or SEC) and other regulators revealed that a large percentage of mutual fund groups and their affiliates were engaged in similar and, in some cases, even more egregious conduct.[10] Since September 2003, the U.S. Senate and House have held fourteen days of hearings on mutual funds[11] and

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(Apr. 28, 2003), *available at* http://www.oag.state.ny.us/press/2003/apr/apr28a_03.html) (last visited June 10, 2004). *See generally* Randall Smith et al., *Wall Street Firms to Pay $1.4 Billion to End Inquiry*, WALL ST. J., Apr. 29, 2003, at A1.

[9] *See* Robert Frank, *Now, Mutual Funds Under Fire*, WALL ST. J., Sept. 4, 2003, at C1.

[10] *See, e.g.*, *Testimony Concerning Commission Activity to Combat Misconduct Relating to Mutual Funds: Before the Senate Subcomm. on Financial Management, the Budget, and International Security, Comm. on Governmental Affairs*, 108th Cong. 13-21 (2003) (statement of Stephen M. Cutler, Director, Division of Enforcement, SEC) *available at* http://govt-aff.senate.gov/_files/110303cutler.pdf (last visited June 10, 2004) (relating SEC findings that more than 25% of brokers surveyed permitted late trading of fund shares; more than 10% of funds groups surveyed were aware of late trading of their shares; almost 30% of brokers surveyed assisted fund market timers and almost 70% of brokers surveyed were aware of customers' market timing; more than 50% of fund groups surveyed had arrangements with market timers; and more than 30% of funds surveyed selectively disclosed portfolio information in ways that may have disadvantaged the funds). For examples of allegations of more egregious conduct, see *State of New York v. Pilgrim Baxter & Associates, Ltd.* (N.Y. Sup. Ct. Nov. 20, 2003), *available at* http://www.oag.state.ny.us/press/2003/nov/pilgrim_baxter.pdf (last visited June 10, 2004) (alleging portfolio manager and CEO of fund manager engaged in self-dealing trading in the mutual funds they managed) and *SEC v. Scott*, No. 03-12082-EFH (D.Mass. Oct. 28, 2003), *available at* http://www.sec.gov/litigation/complaints/comp18428.htm (last visited June 10, 2004) (alleging that portfolio managers engaged in self-dealing trading in funds that they managed).

[11] The Senate Committee on Banking, Housing and Urban Affairs held ten days of hearings. *See Review of Current Investigations and Regulatory Actions*

introduced six mutual fund-related bills,[12] and the Commission has issued twelve mutual fund-related rulemaking pro-

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Regarding the Mutual Fund Industry: The SEC's Perspective: Before the Senate Comm. on Banking, Housing and Urban Affairs, 108th Cong. (Apr. 8, 2004); *Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: Fund Costs and Distribution Practices: Before the Senate Comm. on Banking, Housing and Urban Affairs*, 108th Cong. (Mar. 31, 2004); *Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: Examining Soft-Dollar Practices: Before the Senate Comm. on Banking, Housing and Urban Affairs*, 108th Cong. (Mar. 31, 2004); *Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: Fund Operations and Governance: Before the Senate Comm. on Banking, Housing and Urban Affairs*, 108th Cong. (Mar. 23, 2004); *Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: The Regulatory Landscape: Before the Senate Comm. on Banking, Housing and Urban Affairs*, 108th Cong. (Mar. 10, 2004); *Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: Fund Operations and Governance: Before the Senate Comm. on Banking, Housing and Urban Affairs*, 108th Cong. (Mar. 2, 2004); *Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: Fund Operations and Governance: Before the Senate Comm. on Banking, Housing and Urban Affairs*, 108th Cong. (Feb. 26, 2004); *Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: Understanding the Fund Industry from the Investor's Perspective: Before the Senate Comm. on Banking, Housing and Urban Affairs*, 108th Cong. (Feb. 25, 2004); *Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: Before the Senate Comm. on Banking, Housing and Urban Affairs*, 108th Cong. (Nov. 20, 2003); *Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: Before the Senate Comm. on Banking, Housing and Urban Affairs*, 108th Cong. (Nov. 18, 2003). The Senate Subcommittee on Financial Management, the Budget, and International Security, Committee on Governmental Affairs held two days of hearings. *See Oversight Hearing on Mutual Funds: Hidden Fees, Misgovernance and Other Practices that Harm Investors: Before the Senate Subcomm. on Financial Management, the Budget, and International Security, Comm. on Governmental Affairs*, 108th Cong. (2004); *Mutual Funds: Trading Practices and Abuses that Harm Investors: Before the Senate Subcomm. on Financial Management, the Budget, and International Security, Comm. on Governmental Affairs*, 108th Cong. (2003). The House Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises, Committee on Financial Services held two days of hearings. *See Mutual Funds: Who's Looking Out for Investors?: Before the House Subcomm. on Capital Markets, Insurance, and Government Sponsored Enterprises, Comm. on Financial Services*, 108th Cong. (2003).

[12] *See* Mutual Fund Reform Act of 2004, S. 2059, 108th Cong.; Mutual Fund Investor Confidence Restoration Act of 2003, S. 1971, 108th Cong.; Mutual Fund Investor Protection Act of 2003, S. 1958, 108th Cong.; Mutual Fund Transparency Act of 2003, S. 1822, 108th Cong.; Mutual Funds Integrity and Fee Transparency Act of 2003, H.R. 2420, 108th Cong. (passing the House 418 to 2 on November 29, 2003); Securities Fraud Deterrence and Investor Restitution Act of 2003, H.R. 2179, 108th Cong. (focusing not primarily on mutual funds).

posals.[13] The attendant decline in the public's opinion of the mutual fund industry was reflected by Senator Peter Fitzgerald's statement at the first Congressional hearing on the scandal: "the mutual fund industry is now the world's largest skimming operation."[14]

Even when the *Canary* complaint was just a twinkle in New York Attorney General Spitzer's eye, however, the mutual fund industry's reputation had been experiencing a rough ride. In 2002, for example, the industry was gripped by a widely publicized and contentious debate about an SEC proposal to require funds to disclose how they vote proxies of the

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[13] *See* Disclosure Regarding Portfolio Managers of Registered Management Investment Companies, Investment Company Act Release No. 26383 (Mar. 11, 2004), 69 Fed. Reg. 12752 (Mar. 17, 2004); Mandatory Redemption Fees for Redeemable Fund Securities, Investment Company Act Release No. 26375A (Mar. 5, 2004), 69 Fed. Reg. 11762 (Mar. 11, 2004); Prohibition on the Use of Brokerage Commissions to Finance Distribution, Investment Company Act Release No. 26356 (Feb. 24, 2004), 69 Fed. Reg. 9726 (Mar. 1, 2004); Disclosure Regarding Approval of Investment Advisory Contracts by Directors of Investment Companies, Investment Company Act Release No. 26350 (Feb. 11, 2004), 69 Fed. Reg. 7852 (Feb. 19, 2004); Confirmation Requirements and Point of Sale Disclosure Requirements for Transactions in Certain Mutual Funds and Other Securities, and Other Confirmation Requirement Amendments, and Amendments to the Registration Form for Mutual Funds, Investment Company Act Release No. 26341 (Jan. 29, 2004), 69 Fed. Reg. 6438 (Feb. 10, 2004); Investment Advisor Codes of Ethics, Investment Company Act Release No. 26337 (Jan. 20, 2004), 69 Fed. Reg. 4040 (Jan. 27, 2004); Investment Company Governance, Investment Company Act Release No. 26323 (Jan. 15, 2004), 69 Fed. Reg. 3472 (Jan. 23, 2004); Disclosure of Breakpoint Discounts by Mutual Funds, Investment Company Act Release No. 26298 (Dec. 17, 2003), 68 Fed. Reg. 74732 (Dec. 24, 2003); Amendments to Rules Governing Pricing of Mutual Fund Shares, Investment Company Act Release No. 26288 (Dec. 11, 2003), 68 Fed. Reg. 70388 (Dec. 17, 2003); Disclosure Regarding Market Timing and Selective Disclosure of Portfolio Holdings, Investment Company Act Release No. 26287 (Dec. 11, 2003), 68 Fed. Reg. 70402 (Dec. 17, 2003); Exemption from Shareholder Approval for Certain Subadvisory Contracts, Investment Company Act Release No. 26230 (Oct. 23, 2003), 68 Fed. Reg. 61720 (Oct. 29, 2003); Fund of Funds Investments, Investment Company Act Release No. 26198 (Oct. 1, 2003), 68 Fed. Reg. 58226 (Oct. 8, 2003); *see also* Request for Comments on Measures to Improve Disclosure of Mutual Fund Transaction Costs, Investment Company Act Release No. 26313 (Dec. 18, 2003), 68 Fed. Reg. 74820 (Dec. 24, 2003) (asking for comments on improving disclosure of mutual fund portfolio transaction costs).

[14] Kathleen Day, *Lawmakers Lambaste Mutual Funds; Key Senate, House Members Chastise Industry Amid Reports of Abuse*, WASH. POST, Nov. 4, 2003, at E01.

companies held in their portfolios.[15] Unions favoring the proposal held public rallies criticizing the fund industry for covering up conflicts of interest.[16] The chairmen of the two largest fund complexes complained in a joint *Wall Street Journal* editorial that disclosure of proxy votes would enable special interests to hijack the proxy voting process,[17] while thousands of public comments supporting the proposal poured into the Commission.[18] This debate was widely covered by print media[19] and even earned a segment on NBC Nightly News with Tom Brokaw.[20] In March 2003, the SEC, National Association of Securities Dealers and the New York Stock Exchange announced that inspections of forty-three registered broker-dealers revealed that in one-third of the cases in which shareholders buying fund shares were entitled to commission discounts, the discounts were withheld.[21] The same month,

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[15] *See* Disclosure of Proxy Voting Policies and Proxy Voting Records by Registered Management Investment Companies, Investment Company Act Release No. 25739 (Sept. 20, 2002), 67 Fed. Reg. 60828 (Sept. 26, 2002) (proposing release); Disclosure of Proxy Voting Policies and Proxy Voting Records by Registered Management Investment Company Act Release No. 25922 (Jan. 31, 2003), 68 Fed. Reg. 6564 (Feb. 7, 2003) (adopting release).

[16] *See* John Waggoner, *Funds Resist Call to Tell Proxy Votes*, USA TODAY, Dec. 5, 2002, at 4B (describing AFL-CIO protests at nineteen Fidelity investor centers).

[17] John J. Brennan & Edward C. Johnson, *No Disclosure: The Feeling Is Mutual*, WALL ST. J., Jan. 14, 2003, at A14.

[18] The Commission received approximately 8000 comment letters on the proposal, of which the overwhelming majority were in support. *See* Disclosure of Proxy Voting Policies and Proxy Voting Records by Registered Management Investment Companies, Investment Company Act Release No. 25922 (Jan. 31, 2003), 68 Fed. Reg. 6564 (Feb. 7, 2003).

[19] *See, e.g.*, Kathleen Day, *SEC Wants Funds to Disclose Votes*, WASH. POST, Sept. 20, 2002, at E3; Amy Domini, *It's Time to Lift Shroud on Funds' Proxy Votes*, BOSTON GLOBE, Sept. 22, 2002, at E4; Julie Earle, *Mutual Funds Hit by SEC Move on Voting Disclosure*, FIN. TIMES (London), Sept. 20, 2002, at 32; Josh Friedman, *SEC Proposes Proxy Vote Disclosure Rule*, L.A. TIMES, Sept. 20, 2002, at 9; Allison Linn, *Mutual Funds Face Disclosure on Proxies*, ROCKY MOUNTAIN NEWS (Denver), Sept. 21, 2002, at 4C; Michael Schroeder, *Mutual Funds Could Be Forced to Disclose Their Proxy Votes*, WALL ST. J., Sept. 20, 2002, at C15; *SEC Proposes Disclosure of Votes by Funds*, CHI. TRIB., Sept. 22, 2002, at C18; James Toedtman, *SEC: End the Secrecy On Funds Proxy Votes*, NEWSDAY, Sept. 20, 2002, at A52.

[20] Tom Brokaw & Anne Thompson, *SEC Requires Mutual Fund Managers to Reveal How They Vote* (NBC News Transcripts Jan. 23, 2003).

[21] *See* SEC, Joint SEC/NASD/NYSE Report of Examinations of Broker-Dealers

Representative Richard Baker, chairman of the House Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises, introduced a mutual fund reform bill[22] on which he held hearings in March and June of 2003.[23]

Thus, in January 2004 the time was ripe for a high-level meeting of key policymakers in the mutual fund industry. Mutual fund policy debates had relocated from the back rooms of the Commission to center stage in the public discourse, and the Summit brought together an impressive cast of experts and policymakers to debate major issues facing the fund industry:

- Mr. Barry P. Barbash, Partner, Shearman & Sterling (formerly, Director, Division of Investment Management, Securities and Exchange Commission);
- Mr. John C. Bogle, Founder and former Chairman of The Vanguard Group; President, Bogle Financial Markets Research Center;
- Mr. Mercer E. Bullard (moderator), Assistant Professor of Law, University of Mississippi School of Law; Founder and President, Fund Democracy;
- The Honorable Harvey Goldschmid, Commissioner, Securities and Exchange Commission; Dwight Professor of Law, Columbia University School of Law (on leave);
- Mr. Paul G. Haaga, Jr., Executive Vice President, Capital Research and Management Company; Chairman, Investment Company Institute;
- Mr. Don Phillips, Managing Director, Morningstar, Inc.;
- Ms. Linda Dallas Rich, Senior Counsel, Committee on

Regarding Discounts on Front-End Sales Charges on Mutual Funds (March 2003), *available at* http://www.sec.gov/news/studies/breakpointrep.htm (last visited June 10, 2004).

[22] Mutual Funds Integrity and Fee Transparency Act of 2003, H.R. 2420, 108th Cong. On November 19, 2003, the Act was passed by the House 418 to 2.

[23] *The Mutual Funds Integrity and Fee Transparency Act of 2003: Hearing on H.R. 2420 Before the Subcomm. on Capital Markets, Insurance and Government Sponsored Enterprises, Comm. on Financial Services*, 108th Cong. (June 18, 2003); *Mutual Fund Industry Practices and their Effect on Individual Investors, Hearing Before the House Subcomm. on Capital Markets, Insurance and Government Sponsored Enterprises, Comm. on Financial Services*, 108th Cong. (Mar. 12, 2003).

Financial Services, U.S. House of Representatives;
- Mr. John W. Rogers, Jr., Chairman and Chief Executive Officer, Ariel Capital Management, Inc.;
- Ms. Barbara Roper, Director of Investor Protection, Consumer Federation of America;
- Mr. Paul F. Roye, Director, Division of Investment Management, Securities and Exchange Commission;
- Mr. Erik R. Sirri, Walter H. Carpenter Professor of Finance, Babson College (formerly, Chief Economist, Securities and Exchange Commission); and
- Mr. Craig S. Tyle, General Counsel, Investment Company Institute.[24]

As might be expected from such a group, the discussion was lively and robust. The remainder of this article follows the sequence of discussion topics: Part II: The Regulation of Fund Fees; Part III: The Role of Fund Directors; Part IV: Fund Distribution Practices; Part V: Disclosure and Investor Decisionmaking; and Part VI: Conclusion: The Future of the Fund Industry.

II. THE REGULATION OF FUND FEES

Over the last few decades, no mutual fund topic has generated as much debate as fund fees,[25] and Mr. Bogle's unequivocal view on fund fees shows why: "fees are too high, much too high."[26] But how do we know they are too high? And if we can agree they are too high, what does that mean the role of government should be in reducing them? As this part of the panel discussion illustrated, these questions are rich with implications regarding the role of government in the regulation of the private business sector.

The question of whether fees are too high often begins with an analysis of whether fees are going up or down. There

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[24] Mr. Tyle recently left the Investment Company Institute to become a partner at the firm of Shearman & Sterling.

[25] *See, e.g., Improving Price Competition for Mutual Funds and Bonds, Hearing Before the House Subcomm. on Finance and Hazardous Materials, Comm. on Commerce*, 105th Cong. (1998).

[26] *See infra* text 1155.

was little agreement at the Summit, however, about whether fees have increased or decreased in recent years. Mr. Tyle argued, "when you . . . look at the total cost that an investor pays, every study that has examined it has concluded over the last twenty years that [fund] costs have come down and have come down dramatically."[27] Ms. Rich countered that "studies that show that for equity mutual funds those costs have increased over recent years," citing two studies by the Government Accounting Office in 2000 and 2003.[28]

The studies relied on by Mr. Tyle and Ms. Rich considered fund fees as a percentage of assets, whereas Mr. Bogle took a different perspective. He argued that fees are too high in light of the amount of the market's return given up to fees across the fund industry as a whole. He noted that over the last 20 years, equity funds had an annual return of 10%, compared with the stock market's return of thirteen percent. Mr. Bogle continued, "So, if you'd simply bought the stock market, you would have ended up that period with $114,000 on an initial investment of $10,000. If you'd bought the average equity fund, you would have ended up with $61,000."[29] Mr. Rogers cautioned that funds, as a group, must necessarily underperform the market by the amount of their expenses, and that "there shouldn't be a shock that the overall returns are going to be less than the . . . average market because the average market doesn't include fees."[30]

Mr. Haaga questioned using market comparisons to evalu-

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[27] *See infra* text 1160; *see, e.g.,* Investment Company Institute, *The Cost of Buying and Owning Mutual Funds*, 13 FUNDAMENTALS 1-23 (Feb. 2004), *available at* http://www.ici.org/statements/res/fm-v13n1.pdf.

[28] *See infra* text 1161; *see also* Gen. Accounting Office, Mutual Funds: Information on Trends in Fees and their Related Disclosure, GAO-03-551T (2003); Gen. Accounting Office, Mutual Fund Fees: Additional Disclosure Could Encourage Price Competition, GAO/GGD-00-126 (2000); SEC, Report on Mutual Fund Fees and Expenses (Dec. 2000).

[29] *See infra* text 1156; *see also Testimony Concerning the Mutual Funds Integrity and Fee Transparency Act of 2003: Before the Subcomm. on Capital Markets, Insurance and Government Sponsored Enterprises, Comm. on Financial Services*, 108th Cong. 1-2 (June 18, 2003) (noting fund expenses had risen from $523 million in 1979 to $64 billion in 2001; after a thirty-four percent decline in fund assets from 1999 to 2002, total fund expenses increased by $4 billion).

[30] *See infra* text 1162.

ate fund fees, noting that the most common proxy for the market—the large capitalization S&P 500 index—is a poor benchmark for equity funds, which are more heavily weighted than the S&P 500 in small capitalization stocks. Indeed, he doubted the possibility of ever knowing whether fees were too high: "I can't tell. I'm not sure anybody can tell."[31] However, he suggested that "external evidence" might suggest that fees are not too high, including intense competition in the fund industry, the high percentage of new investments in 2003 that flowed "to the three lowest cost fund groups," and the industry's enormous growth to $7.3 trillion in assets and ownership by fifty percent of U.S. households.[32]

Such diverse views about fund fees—whether they are going up or they are going down, we can't know either way—led some participants to reconsider what it means to ask whether fund fees are too high. Professor Sirri queried, "[C]ompared to what? [The argument that fees are too high may simply be] a proxy . . . another way of saying that investors are insufficiently price sensitive."[33] It seems that at least some investors do not give fund fees their due. As Mr. Phillips noted, there are "short-term taxable bond funds . . . that have a five per cent load and a one-and-a-half per cent expense ratio for an asset class that's returning about five per cent."[34] Giving up all of the first year's return and about one-third of the return after that, Mr. Phillips argued, does not offer the investor "a winning value proposition."[35]

Ms. Roper offered another way of looking at the question. She conceded that, on the surface, "it appears that the mutual fund industry is a highly competitive market," but "for a portion of the marketplace you do not have effective competition."[36] For example, as Ms. Roper explained, sales may be driven by high sales compensation rather than competition, and, in some cases, such as retirement plans, investors may

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[31] *See infra* text 1156.

[32] *Id.* at 1157; *see supra* notes 4-6 and accompanying text.

[33] *See infra* text 1159.

[34] *Id.* at 1183.

[35] *Id.*

[36] *See infra* text 1158.

have limited or no lower cost options.[37]

If the issue is whether investors are price insensitive, and not whether fees are going up or down, then "what do you want to do about the fact that the people are insufficiently price sensitive?" asked Professor Sirri.[38] Mr. Haaga's answer was that the existence of healthy competition and the migration of fund assets to low cost funds show that the problem of price insensitivity is being addressed. This argument is supported by at least some studies that weight fees on a sales-volume basis, that is, based on the fees charged on shares purchased by investors during different periods. Such an approach reflects the view that we should focus not on what investors are paying but on what decisions investors are making. This view measures society's success in improving investors' price sensitivity by evaluating price competition. In contrast, Mr. Bogle seems to believe that the question for regulators should be whether fees, as an objective matter, are too high. He argues that expense ratios have increased, and even where they have decreased, fees are higher in absolute terms than they should be in view of the enormous asset growth in the industry.

Under Mr. Haaga's view, the government might intervene only in the absence of evidence of effective price competition, even when absolute fees have increased. Under Mr. Bogle's view, the government might also consider whether funds offer a reasonable value proposition and take action, at least in some situations, when they do not. Professor Sirri captured these disparate views in commenting that the government can act "*in loco parentis* . . . saying: I'm going to take care of this problem for you and make this industry behave as if consumers were more price sensitive," or it can "cause people to think in a more price-sensitive manner by perhaps producing information or otherwise making it easier for them to comparison shop."[39]

The discussion of concrete regulatory measures that might

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[37] *See id.* at 1157-58.
[38] *Id.* at 1159.
[39] *Id.* at 1160.

be taken followed a similar dichotomy. On the one hand, there was popular support for enhanced price transparency with no expressed disagreement. Commissioner Goldschmid, Ms. Roper, Ms. Rich and Professor Sirri all expressed strong support for improved price transparency. Mr. Phillips suggested that higher fund fees abroad may be partly attributable to inferior disclosure rules, and Mr. Roye described a number of reforms that the Commission had implemented, proposed or planned to propose to promote greater price transparency. Enhanced price transparency is, of course, one way to "cause people to think in a more price-sensitive manner."[40]

On the other hand, there was sharp disagreement about the government's attempt to "make this industry behave as if consumers were more price sensitive."[41] Although no one disagreed with statements by Commissioner Goldschmid, Mr. Roye and Mr. Barbash that the Commission should not set fees, Ms. Roper pointed out that Section 36 of the Investment Company Act authorizes the Commission to sue fund managers and fund directors when fund fees are unreasonable, and the Commission had failed to exercise this authority. "[W]hen you have a government that has the power to take action against managers or boards if fees are not reasonable, and they don't use it," she argued, "it sends a message that . . . this is really pretty much okay with us."[42] Ms. Roper asked why there can be an "S&P 500 index fund with a 2.18% expense ratio when Vanguard or Fidelity can do it for 0.18% or 0.19%."[43] Mr. Roye commented that one difficulty with bringing an excessive fees case was that, in some cases, "the fees aren't out of line with what you see elsewhere in the industry. So if you look at standards the courts have set, we can't make that kind of case."[44] Ms. Roper responded that "if everybody

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[40] *Id.*

[41] *Id.* at 1159-60.

[42] *Id.* at 1171.

[43] *Id.*; *see* Press Release, Consumer Federation of America and Fund Democracy, Investors Waste Hundreds of Millions Annually on Over-priced Money Market and S&P 500 Index Funds (July 23, 2003), *available at* http://www.funddemocracy.com/Wasted%20Fees%20Press%20Release.pdf (last visited June 18, 2004)

[44] *See infra* text 1180. The generally accepted standard for evaluating fund

is charging an unreasonable amount, [the fees] all look reasonable," and suggested that the Commission look instead at "the cost of the service . . . and what's a reasonable profit for offering that service to get at a reasonable fee."[45]

III. THE ROLE OF FUND DIRECTORS

These divergent views regarding the regulation of fund fees were also reflected in the discussion of the role of fund directors. Under the Investment Company Act, fund directors are obligated to review and approve the fund's contract with the fund manager.[46] Fund directors also have a fiduciary duty with respect to fees received by fund managers, and, as

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fees under Section 36 was established in *Gartenberg v. Merrill Lynch Asset Management, Inc.*, 694 F.2d 923, 928 (2d Cir. 1982) (holding that to trigger liability under Section 36, one must show that a fund's fees are "so disproportionately large that [they] bear no reasonable relationship to the services rendered and could not have been the product of arms-length bargaining").

[45] *See infra* text 82. This discussion echoed a disagreement between New York. Attorney General Spitzer and the SEC regarding their respective settlements with Alliance Capital Management. *See* In the Matter of Alliance Capital Management, L.P., Investment Company Act Release No. 26312 (Dec. 18, 2003), *amended by* In the Matter of Alliance Capital Management, L.P., Investment Company Act Release No. 26312A (Jan. 15, 2004). *See generally* Deborah Solomon, *It's Spitzer vs. SEC on Mutual Funds' Fees*, WALL ST. J., Dec. 19, 2003, at C1. The settlements were similar except that Alliance agreed with Spitzer to reduce its fees by $350 million. The SEC indirectly criticized Spitzer's decision to insist on a fee reduction on the ground that this was "a case about illegal market timing, not fees." SEC, Statement of the Commission Regarding the Enforcement Action Against Alliance Capital Management, L.P. (Dec. 18, 2003). Spitzer responded that the SEC's settlement as "inadequate to address all of the harms uncovered in our investigation." Press Release, Office of New York State Attorney General, Statement By Attorney General Eliot Spitzer Regarding Mutual Fund Fee Reduction (Dec. 18, 2003), *available at* http://www.oag.state.ny.us/press/2003/dec/dec18d_03.html) (last visited June 15, 2004). In subsequent cases, Spitzer has continued to insist on fee reductions in scandal-related settlements, while the Commission has not. *See, e.g.*, Press Release, Office of New York State Attorney General, *MFS Settles Market-Timing Issues* (Feb. 5, 2004), *available at* http://www.oag.state.ny.us/press/2004/feb/feb05a_04.html (last visited June 15, 2001) (stating in settlement with New York Attorney General Eliot Spitzer, Massachusetts Financial Services Co. agreed to a $125 million reduction in fees); In the Matter of Massachusetts Financial Services Co. et al., Investment Company Act Release No. 26347 (Feb. 5, 2004) (noting settlement between Commission and MFS did not include fee reduction).

[46] *See* 15 U.S.C. § 80a-15 (2000).

noted by Ms. Roper, the Act authorizes the Commission to bring claims against fund directors who violate this duty.[47] Mr. Roye stated that fees "may be the most important issue that [fund directors] have responsibility for."[48]

One way that government could, in Professor Sirri's words, "make [the fund] industry behave as if consumers were more price sensitive" would be to cause fund directors to negotiate harder with fund managers to lower fees.[49] Commissioner Goldschmid argued that "you can't simply . . . let the market decide . . . . provid[ing] better disclosure to consumers . . . [is] not going to be good enough."[50] He continued, "[t]hat's why governance is so important . . . . [the] independent directors . . . have to be far more effective and active than they've been in the past."[51] Commissioner Goldschmid and Mr. Roye offered a series of governance reforms that would enhance the board's independence and accountability as a way to make fund boards more effective shareholder representatives. Commissioner Goldschmid argued, for example, that having an independent chairman "is critically important. There's no way of avoiding that he or she will deal with people, will set agendas, will guide discussions and is in a position that people are invariably looking to the leader."[52] Mr. Roye argued for additional steps, including the Commission's proposals to require that boards be at least seventy-five percent independent[53] and keep records on the basis for their renewal of the advisory contract.[54]

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[47] *See* 15 U.S.C. § 80a-35(b).

[48] *See infra* text 1174.

[49] *Id.* at 1160.

[50] *Id* at 1163.

[51] *Id.*

[52] *Id.* at 1176-77. The Commission recently required that the boards of funds that rely on certain exemptive rules have an independent chairman. Investment Company Governance, Investment Company Act Release No. 26323 (Jan. 15, 2004), 69 Fed. Reg. 3472 (Jan. 23, 2004) (proposing release); Investment Company Act Release No. 26520 (July 27, 2004), 69 Fed. Reg. 46378 (Aug. 2, 2004) (adopting release).

[53] The Commission recently required that funds that rely on certain exemptive rules have boards that are at least seventy-five percent independent. *Id.*

[54] The Commission has proposed that boards of funds that rely on certain exemptive rules keep records of the basis of their approval of the advisory con-

Perhaps these proposals will make directors more effective, but more effective at what? The discussion revealed a chasm of expectations ranging from passive oversight to aggressive policing. Mr. Bogle cited Warren Buffett's oft-quoted characterization of fund directors as submissive "cocker spaniels."[55] "[T]he [Investment Company] Act intended for the directors to be dobermans," he argued, and "I'm a doberman guy."[56] For statutory support, Mr. Bogle cited the Act's preambular declaration "that the national public interest and the interest of investors are adversely affected . . . when investment companies are organized, operated, managed . . . in the interest of directors, officers, investment advisors . . . rather than in the interest of . . . such companies' security holders."[57] Mr. Phillips suggested that fund directors seem afflicted with "Stockholm syndrome," as evidenced by their using the pronoun "we" at board meetings to refer to the directors and fund's advisors, not the directors and the fund's shareholders.[58]

Other participants adamantly rejected the "doberman" theory of fund directors. Mr. Barbash argued that, under the Investment Company Act, the board's review of the advisory contract is "not a negotiation process; its' an oversight process . . . [T]he independent directors are asked to look over the process . . . [and] make sure that the fee arrangement is within a band of reasonableness, and, if it is, then approve the fee."[59] Mr. Tyle echoed that the "directors have an important role, but it is not a *de novo* setting-the-fee role. It is to act as an additional check to make sure the fees fall within a reasonable band."[60]

Commissioner Goldschmid countered that you need "an active board" to help "keep fees in line,"[61] and that

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tract. *Id.*

[55] *See infra* text 1170.

[56] *Id.*

[57] 15 U.S.C. § 80a-1(b)(2); *see infra* text 1163.

[58] *See infra* text 1178.

[59] *Id.* at 1168.

[60] *Id* at 1173.

[61] *Id.* at 1163.

"[w]hatever Congress was thinking in 1940, the role of directors must be a far more serious role today than it has been in the past."[62] But neither Commissioner Goldschmid nor Mr. Roye articulated precisely what that role must entail. Mr. Roye disclosed the Commission's plan to require fund directors to explain in shareholder reports "how they arrived at the decision that the fees were fair," and, more importantly, suggested that this disclosure was expected to address specific substantive areas such as "what was being charged to a pension plan for the same service as other funds that are managed by the same advisor."[63] Mr. Bogle had specifically cited directors' approval of fund fees that are many multiples of fees charged to an advisor's pension clients, a criticism that echoed a well-publicized debate between New York Attorney General Spitzer and the fund industry in the months preceding the Summit.[64] The Commission's specific identification of the kinds of factors fund directors must consider when evaluating the advisory contract begins to give content to their fiduciary duty, but this step still falls short of a promise to enforce such standards. Commissioner Goldschmid warned that the Commission would "use the law where fraud has occurred to go

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[62] *Id.* at 1170.

[63] *Id.* at 1180; *see also* Disclosure Regarding Approval of Investment Advisory Contracts by Directors of Investment Companies, Investment Company Act Release No. 26350 (Feb. 11, 2004), 69 Fed. Reg. 7852 (Feb. 19, 2004) (proposing release); Disclosure Regarding Approval of Investment Advisory Contracts by Directors of Investment Companies, Investment Company Act Release No. 26846 (June 23, 2004), 69 Fed. Reg. 39798 (June 30, 2004) (adopting release).

[64] *See* Press Release, Office of the New York State Attorney General, Statement by Attorney General Eliot Spitzer Regarding the Investment Company Institute's Mutual Fund Fee Report (Jan. 6, 2004), *available at* http://www.oag.state.ny.us/press/2004/jan/jan06b_04.html (last visited June 15, 2004) (rejecting conclusions of Investment Company Institute report, infra, as analytically flawed); Investment Company Institute, *Institutional Investment Management: A Comparison of Portfolio Management Expenses of Mutual Funds and Defined Benefit Pension Plans*, 12 FUNDAMENTALS 1-4 (Nov. 2003), *available at* http://www.ici.org/statements/res/fm-v12n5.pdf (arguing that expenses are roughly the same at mutual funds and pension plans); *Testimony of New York Attorney General Eliot Spitzer Before the Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises, Committee on Financial Services*, 108th Cong. (Nov. 4, 2003) (citing research showing that mutual funds pay higher fees than pension funds).

after those people and fund directors who are negligent or reckless in important areas," but this comment was directed at the kinds of abuses revealed in the course of the ongoing mutual fund scandal and did not suggest that a director's failure to fully and fairly evaluate the advisory contract might fall within the Commissioner's conception of "fraud."[65]

IV. Fund Distribution Practices

The discussion of fund distribution practices began with the pejorative image of fund distribution costs as, to use Mr. Bogle's words, "a dead weight . . . [that] drives returns down . . . [O]verall, marketing costs are destructive."[66] Mr. Haaga responded that this oft-stated view was the product of our being "trapped in vocabulary, and the vocabulary we're trapped in here is 'sales.'"[67] Mr. Haaga explained that distribution fees pay for advice that investors need and request, for which they should reasonably expect to pay. Mr. Phillips followed that "what's wrong is this notion that advice should be free. I think people giving good advice deserve to be compensated."[68]

Ms. Rich suggested that the often negative perception of fund distribution costs was not a function of misunderstanding their purpose so much as their lack of transparency. She noted that revenue sharing payments from fund advisors to brokers were not disclosed and 12b-1 fees "are not as noticeable as a front-end load because they are imbedded in the structure of the expense ratio."[69] She also stated, "when something is being hidden away, it looks like it's a bad thing."[70] She further argued that "transparency would help to eliminate the pejorative sense of distribution because there's nothing wrong with having investors choose to pay for advice, but they just don't

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[65] *See infra* text 1182.
[66] *Id.* at 1184-85.
[67] *Id.* at 1185.
[68] *Id.* at 1187.
[69] *Id.* at 1189.
[70] *Id.*

realize that they're doing it."[71]

There was general agreement with Ms. Rich regarding the importance of fee transparency, as was generally expressed during the Summit's opening discussion about fund fees. Mr. Phillips lamented that many investors had boasted to him that they were invested in a no-load fund, when in fact they had purchased Class B shares that imposed an asset-based distribution (12b-1) fee. Mr. Roye described efforts to improve the transparency of distribution costs through enforcement actions[72] and new requirements for disclosure on fund transaction confirmations, which are sent to shareholders after their purchases have been completed.[73] Mr. Barbash lauded the SEC's proposal to require disclosure of distribution costs at the time the investment is made "as the best place to present to a customer or client where the conflicts of interest are and what the problems that person should be thinking about."[74]

One factor that has adversely affected the transparency of fund distribution compensation is its complexity. Regarding the proliferation of fund share classes, Mr. Phillips lamented that "[w]e have hugely complicated this issue in that the beauty of mutual funds was their simplicity."[75] "[I]t's more confusing now with different classes," Mr. Tyle agreed, but "that comes with additional choice."[76] He and Mr. Roye both noted that 12b-1 fees, for example, offer investors an installment alternative to a front-end load. It is not clear, however, what the availability of the 12b-1 alternative to a front-end load has to do with rule 12b-1 per se, as the rule has no necessary bearing on an investor's ability to pay a load on an installment basis directly to the broker (or on the broker's authority to receive such a payment).

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[71] *Id.*

[72] *See, e.g.,* In the Matter of Morgan Stanley DW, Inc., Securities Act Release No. 8339 (Nov. 17, 2003) (finding that Morgan Stanley failed to disclose material information to customers regarding distribution costs).

[73] *See* Release No. 26341, *supra* note 13.

[74] *See infra* text 1193.

[75] *Id.* at 1188.

[76] *Id.* at 1190.

Ms. Roper suggested another reason that brokers might prefer being compensated through 12b-1 fees. She raised the possibility that "distribution costs have intentionally gone into hidden channels or less well understood channels because it makes it easier for the broker to tell the investor that they're getting a good deal; you're getting a no-load fund."[77] This comment follows up on Ms. Roper's more general concern that "[b]rokers, despite calling themselves financial consultants or financial advisors, are sales people. They do not have a legal obligation to put your interest ahead of their own . . . [or] ensure that you get the very best product at the best price."[78] Perhaps the reason for the pejorative view of fund distribution arrangements may lie as much with the broker regulation as fund regulation.

V. Disclosure and Investor Decisionmaking

Following the discussion of fund distribution arrangements and before wrapping up with closing thoughts on the future of the fund industry, the Summit participants touched briefly on the question of how to craft effective disclosure for investors. The most common disclosure issue was the problem of determining the proper audience for fund disclosure. Mr. Phillips pointed out that there "is a huge body of people out there helping" to convey information about funds to investors, including academics, financial press, financial planners and third party information providers, and their appetite for the information is growing.[79] Disclosure requirements, he concluded, must "recognize that all of that is part of the market process."[80]

Mr. Roye recognized the breadth of constituents for gov-

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[77] *Id.* at 1197.

[78] *Id.* at 1186. Ms. Roper's comments were an indirect reference to a pending proposal by the Commission to exempt certain brokers who provide investment advice from regulation as investment advisors. *See* Certain Broker-Dealers Deemed Not to be Investment Advisors, Advisors Act Release No. 1845 (Nov. 4, 1999), 64 Fed. Reg. 61226 (Nov. 10, 1999). The Commission has not taken final action on the proposal.

[79] *See infra* text 1200.

[80] *Id.*

ernment-mandated disclosure, but advised that the Commission must also "worry about overwhelming the ordinary retail investors with everything they have a right to know."[81] Mr. Roye argued for a "layered" approach that attempts to provide different information needs by offering different levels of disclosure. Mr. Rogers cautioned that excessive disclosure requirements might "endanger[] the ability for some fund complexes to start. It may become a barrier to entry for the next generation of entrepreneurs in this industry."[82]

Mr. Phillips suggested that for mutual fund disclosure "there's a wonderful template for right-to-know information in corporate America."[83] By analogy, he added, "[f]und managers would not give up the information that they have on corporate America, and yet they turn around and give less information to people making mutual fund decisions."[84] Although Mr. Roye appeared intent on satisfying the appetites of all information consumers, his main goals seemed to be to answer the question, "what does the average investor want and need?" as well as to "focus on how we can improve that disclosure."[85]

Ms. Roper recommended focusing not on "disclosure for the people for whom it already works . . . [but] people for whom it doesn't work."[86] She argued that we should "begin by looking at the people who are making bad decisions and figure out why they're making bad decisions and what would cause them to make better decisions."[87] Mr. Bogle queried whether the problem of fund disclosure lay with the complexity of funds themselves. We need to "get all the complexity and the confusion out of the business," he argued, "complexity is dreadfully expensive and simplicity is marvelously cheap."[88] As noted by Mr. Phillips, the fund industry has frequently opposed disclosure reform on the ground of its cost and com-

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[81] *Id.*
[82] *Id.* at 1202.
[83] *Id.* at 1201.
[84] *Id.*
[85] *Id.* at 1199.
[86] *Id.*
[87] *Id.*
[88] *Id.* at 1197.

plexity, yet, as argued in a recent comment letter submitted by consumer groups to the Commission, to some extent that complexity may be self-regulating in that fund sponsors could reduce and simplify disclosure by doing the same to their fund offerings and distribution arrangements.[89]

VI. Conclusion: The Future of the Fund Industry

The Summit concluded with the participants discussing how the mutual fund industry and fund regulations must change over the next few decades in order for mutual funds to maintain their position as Americans' investment vehicle of choice. The common response was that, especially in view of the ongoing mutual fund scandal, the fund industry and fund regulators must (and would) take steps to restore Americans' trust and confidence in mutual funds. Ms. Rich argued that legislation was needed to ensure that this was accomplished. Mr. Bogle similarly emphasized the importance of trust, tying the issue not to the scandal, however, but to the general shift in the fund industry "from a business of management to a business of marketing."[90]

While it is difficult to argue with the importance of trust to the success of a financial services provider, one might ask in what sense, in light of the substantial asset inflows mutual funds have experienced since the fund scandal erupted,[91] what "trust" has been lost for the fund industry to regain? Legislators and regulators have made much ado about the need to reform fund regulation in order to restore Americans' trust in the mutual fund industry, but positive asset flows into mutual funds may belie this basis for reform. In addition, if effective marketing has been responsible for much of the industry's success over the last quarter century, one might

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[89] *See* Letter from Consumer Federation of America, Fund Democracy, Consumer Action and Consumers Union to Jonathan G. Katz, Secretary, SEC 2–3 (Apr. 21, 2004), *available at* http://www.funddemocracy.com/confirmation%20comment%20letter.pdf (last visited June 15, 2004) (commenting on Commission proposal regarding disclosure of fees on confirmations and at point-of-sale). *See generally* Release No. 26341, *supra* note 13.

[90] *See infra* text 1204.

[91] *See supra* note 6 and accompanying text.

argue that it is the very mutual fund marketing criticized by Mr. Bogle that has generated unparalleled "trust" among investors, to the extent that you measure "trust" by analyzing where investors choose to invest.

Some panelists focused on issues other than trust. Mr. Barbash also expressed concern that over-regulation and consolidation might deter entrepreneurs from entering the business, and Professor Sirri and Mr. Tyle echoed this concern about over-regulation. Commissioner Goldschmid and Mr. Roye expressed assurances that current Commission rulemaking would be sensitive to this concern. Mr. Rogers stated his concern about diversity issues, both in terms of the investing public and the fund industry management.

Interestingly, Ms. Roper, who has been actively engaged in pressing regulators and legislators for mutual fund reforms, was not among those citing the rebuilding of trust as a key determinant of the fund industry's future success. In fact, she did not "think that the industry really does have to change to continue to be very successful. For people who have only a modest amount of money to invest, the only way you can get broad diversification is through mutual funds."[92] Professor Sirri also saw the question not as whether the industry maintains the trust of investors, but as one of what mutual funds provide and whether they will continue to be a popular way of providing it. "There is, in fact, nothing special to me about a mutual fund. They're wonderful vehicles to pool capital to save and to get exposure to the market. But I think to get at [the question of] where are mutual funds going to sit ten plus years from now, I think it depends on how innovative they are and how innovative this business is."[93] The purpose of mutual funds, he continued, is to solve "broad life cycle problems," such as how to pay for your home, your children's education and your retirement, and the future success of mutual funds depends on how well they help solve these problems.[94]

If Ms. Roper's and Professor Sirri's comments are correct,

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[92] *See infra* text 1208.
[93] *Id.* at 1209.
[94] *Id.*

then the early indications are that the current scandal probably has not altered Americans' view of mutual funds as the best way to solve certain "broad life cycle problems" relative to other financial products. If that is so, and a number of the Summit participants, legislators and regulators are, in fact, wrong about mutual fund reform being about restoring America's trust in mutual funds, then why do Ms. Roper and other shareholder advocates, including this author, call so vehemently for such reform?[95]

One possible answer is that the brand that we know as the "mutual fund" owes much of its success to the adaptable nature of fund regulation. Over the last quarter century, regulatory reforms have provided an important and possibly predominant stimulant to fund growth. The law that Congress enacted in 1940 to regulate mutual funds did not permit money market funds, multi-class funds or 12b-1 fees; each of these features was enabled by Commission rulemaking.[96] Permissive rules are not the only rules responsible for the fund industry's success; restrictive rules also have played a key role. Investors would not have been as enamored of mutual funds had the Commission not prohibited late trading[97] and restricted excessive redemption fees,[98] for without those rules

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[95] *See, e.g., Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: Fund Operations and Governance: Before the Senate Committee on Banking, Housing and Urban Affairs*, 108th Cong. (Mar. 23, 2004) (testimony of Mercer Bullard, President and Founder, Fund Democracy, Inc. and Assistant Professor of Law, University of Mississippi School of Law); *Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry: Fund Operations and Governance: Before the Senate Committee on Banking, Housing and Urban Affairs*, 108th Cong. (Mar. 23, 2004) (testimony of Barbara Roper, Director, Investor Protection Consumer Federation of America).

[96] Investment Company Act Rules, 17 C.F.R. § 2a-7 (2003) (permitting the offering of money market funds); § 18f-3 (permitting the sale of multiple classes of shares); § 12b-1 (establishing 12b-1 fees).

[97] Investment Company Act Rule, 17 C.R.F. § 22c-1 (2003) (requiring that fund shares be redeemed at the price next computed after tender).

[98] *See* Fidelity Advisor Korea Fund, Inc., SEC No-Action Letter, [2000-2001 Transfer Binder] Fed. Sec. L. Rep. (CCH) ¶ 78,064, at 77,553 (Mar. 7, 2001) (restating SEC staff position that a redemption fee in excess of two percent of the net redemption amount would raise a question as to whether the shares were "redeemable" as required under the Investment Company Act).

fund shareholders might suffer, respectively, dilution of their investments or the prospect of redeeming their shares at a substantial discount to their fair market value.

Investors who have preferred mutual funds over other investment products have been attracted to the mutual fund brand, which is constituted in part by a particular set of default rules established through government intervention. Recent fund sales could be viewed as an affirmation of confidence, or at least a current expectation, that government actors will continue to adapt the regulatory structure to reflect lessons learned from the mutual fund scandal and as a vote in favor of continuing on a course of constant evaluation and reform. Protestations by government actors that "trust must be restored" could be viewed as interim messages—pending final legislative, regulatory and enforcement action—that these government actors will continue to adapt mutual fund regulation to changing circumstances. The entirety of the Summit discussion captured this vibrant aspect of mutual fund regulation and reinforced the view that, to the extent that mutual funds' success depends on the dynamism of their regulation, the next few decades may very well be successful ones for the fund industry.

THE MUTUAL FUND SUMMIT TRANSCRIPT

Panelists

Mercer Bullard, Moderator
Barry Barbash
John Bogle
Harvey Goldschmid
Paul Haaga
Don Phillips
Linda Dallas Rich
John Rogers
Barbara Roper
Paul Roye
Erik Sirri
Craig Tyle

DEAN DAVIS:

Good morning. I'm Sam Davis, Dean of the University of Mississippi Law School. The Law School is the fourth oldest public law school in the country and is pleased this morning to be the site host for this mutual funds summit. On behalf of the Law School, I want to welcome our distinguished panel, guests to the University, to Ole Miss and to Oxford. And I welcome all of you who are present in the courtroom today as well as those who are joining us via live web cast. Without further adieu, I want to turn the program over to Professor Mercer Bullard who is a member of the faculty here at the Law School and who put this program together and did a splendid job of doing it. I don't know that a more distinguished group of people in this field has been under one roof ever. So with that, Professor Bullard.

PROFESSOR BULLARD:

Thank you, Dean Davis. Thank you all for coming to the summit today. You're really in for a treat. As Dean Davis said, this is probably the greatest collection of mutual fund talent ever assembled under one roof. You're probably familiar with the ongoing mutual fund scandal, but this was begun to be organized long before that started. Mutual funds, with or without the headlines they have been receiving lately, are America's favorite investment vehicle of choice. And the future of mutual funds will have a great impact on the future of our

retirement security. Today we have a group who you've seen in the press often enough, but often these people have had a longstanding relationship. I know that Paul Haaga, for example, was, I think, initially first hired by Jack Bogle. Both Barry Barbash and Paul Roye have been mentors of mine.

This is a group that knows each other well, and I think you'll see an excellent kind of interaction going on here. Also I want to point out that this panel has a very basic agreement about some fundamentals, and one is that America's mutual fund industry is a great institution. It's a great industry. We're here to plumb the depths of some disagreements about that industry and our competing visions for the future, but we all share this common interest in trying to make the mutual fund industry the best service it can provide for America's investors.

I'm going to give a very brief introduction so we can get right into the substance of our panelists. Going around the table, we have Barry Barbash who is a partner of Shearman & Sterling and a former director of the SEC's division of investment management. Next to him is Jack Bogle who is the founder of The Vanguard Group and currently the head of the Bogle Financial Markets Research Center. Next to him is SEC Commissioner Harvey Goldschmid who is also a former general counsel at the SEC and a professor at Columbia Law School.

Next is Paul Haaga who is the chairman of the Investment Company Institute and a senior vice president at Capital Research which is the manager of the American Funds, a fund complex. Next is Don Phillips, who many of you know as managing director of Morningstar, one of the leading providers of third-party information on mutual funds. Next we have Linda Dallas Rich who is senior counsel at the House Financial Services Committee and played a central role in the mutual fund bill that was passed out of the House recently. Next is John Rogers who is the President and Chairman of Ariel Capital Management which is a mutual fund complex. Next to him is Barbara Roper who is the Director of Investor Protection at the Consumer Federation of America which represents consumer groups representing about fifty or sixty million inves-

tors and consumers. Next is Paul Roye who is the current Director of the Division of Investment Management at the SEC. Next is Eric Sirri who is a professor of finance at Babson College, and he is also a former chief economist at the SEC. Finally, Craig Tyle is the general counsel of the Investment Company Institute.

I thought we'd start today's discussion with one of the leading topics that has occupied mutual fund analysts for years and that is the regulation of fund fees. You see a lot of discussion in the press about fund fees, and I think a good place to start is simply to get some feedback on where fund fees are now. There have been a lot of claims that fund fees are too high, and the question I always ask is: Well, how do we know the answer to that question? Why don't we start with our senior statesman on the panel, Jack Bogle. How do you know—if you think they are—if fees are too high?

MR. BOGLE:

Well, fees are too high, much too high. But I want to change the question just a hair and say—are fund's total costs too high—because fees are not the largest part of total costs. An investor should understand that you have your advisory fees, your 12b-1 distribution fees, your operating expenses of the fund, you've got front-end sales charges, custodian costs—all those kind of things and biggest of all, as it turns out, is the cost of portfolio turnover—very, very high, a hundred percent a year in this business, which managers use to pay for brokerage services, distribution services and research services from the brokerage community. These fees come to something like two and half to three percent a year.

It's an unarguable proposition that for the entire mutual fund industry, that's an equity fund number at two and a half to three percent a year, if you come to the total industry—mutual fund industry—the returns earned by mutual fund shareholders fall short of the returns earned by the stock, bond and money market fund business by $130 billion a year. That's the number, and it is unarguable. And, therefore, the returns of funds investors must fall short by that amount. Does it matter? Well, in the last twenty years if you'd bought an equity fund, average equity fund, you would have earned

about ten percent of your money in a stock market that grew at thirteen percent. So, if you'd simply bought the stock market, you would have ended up that period with $114,000 on an initial investment of $10,000. If you'd bought the average equity fund, you would have ended up with $61,000. Does the difference between $61,000 and $114,000 matter? Yes. Is it too big a hunk for the providers of the service and too small a hunk for the shareholders who put their money at work and take all the risks and pay all the costs? Much too high. So we've got to do something about that.

Curiously enough, this industry has grown enormously. Go back to 1965. We had $26 billion of equity fund assets. Now we have $3.3 trillion, and in an industry where the economies of scale of operation are staggering beyond belief, expenses have risen faster than that. While assets have gone up in equity funds 128 times, expenses have gone up from a $134 million to $31.9 billion for equity funds, 238 times.

PROFESSOR BULLARD:

Those are some big numbers. Anybody on the panel want to respond to that?

MR. HAAGA:

Well, my response would be to just be careful of averages; be careful of any number you hear from Jack Bogle.

MR. BOGLE:

He'll give us the right numbers.

MR. HAAGA:

Jack talks about the average fee, the average fund fee going up, during certain periods, and yet no funds raised their fee during those periods. What happened is the industry grew by adding smaller funds of a more expensive type during the periods he cited; therefore, if you're just looking at simple averages—let me get to whether fees are too high.

I don't know whether fees are too high, too low or just right. I can't tell. I'm not sure anybody can tell. But let's look at some of the external evidence that might help you decide whether fees are too high. One of them is competition in the industry. There are 8000 some odd mutual funds; there were a few hundred years ago. There are about 600 fund complexes that are members of the Investment Company Institute. It's

an industry that has very low barriers to entry, many new entrants and a great deal of competition.

Do shareholders understand the cost? More than all of the net flows that came into the equity funds in the industry last year went to the three lowest cost fund groups of their kind. So, I think shareholder behavior would tell you that they do understand what the costs are, that they do respond to cost and that they are going for the lower cost funds. Is there good value? Is there a value for proposition to funds? I guess if it was as bad as Jack would have you believe, how did we get to $7.3 trillion? How did we get from six percent of the American households owning funds in 1982 to fifty percent of households owning funds in 2000? This is the greatest hoax ever perpetrated.

Lastly, I tell you to look at the process for setting fees. Is there an effective process? There are limitations on grossly excessive fees. There is a fiduciary duty requirement in the '40 Act that has been applied to the outliers, and there is a very robust process which takes very much of our efforts to go to the boards of directors and negotiate or have them oversee fees. If you go look at what's happened, don't look at Jack's averages because that takes the new higher cost entrants in there. Just go look at what's happened in individual funds, get the largest funds from twenty or thirty years ago and trace what's happened within those individual funds, and you'll see a real value proposition in sharing of economies of scale.

PROFESSOR BULLARD:

How about a view outside the industry? Ms. Roper, do you have something to add to that?

MS. ROPER:

Sure. I mean, if you look at the surface, it appears that the mutual fund industry is a highly competitive market. As you've said, there are thousands of funds, hundreds of fund companies. And there is a portion undoubtedly of the industry which is competitive and cost competitive. The problem is that a large part of this industry competes to be sold. It doesn't compete to be bought. And when you compete to be bought, you offer a good product with good service and a reasonable price. And when you compete to be sold, you compete by offer-

ing generous compensation to the salesperson. And because the mutual fund underwriter sets the compensation level, they compete in a way that drives costs to investors up, not down. And so for a portion of the market place, you do not have effective competition.

In retirement plans, investors have virtually no choice. The selections available to them are quite narrow. So the theory that this highly competitive industry ought to be disciplining prices doesn't really bear out in the market reality.

PROFESSOR BULLARD:

Mr. Phillips, you wanted to add something to that?

MR. PHILLIPS:

Yes, one thing. I would like to throw in some international perspective. Morningstar now tracks funds in over seventeen different countries. One thing that I've found is that mutual fund fees in the U.S. are a fraction of that anywhere else in the world. So the value proposition for funds is far better here than it is anywhere else, and that's a major advantage. And to get back to your first point—that this is effectively a good industry, but there's a question: Can it be a better one? Paul cited the growth of the industry over the last twenty years and said, "How could this growth occur if the value proposition wasn't good?" Well, the answer is simple.

We've had a phenomenal bull market. And the question we need to be asking—the industry needs to be asking is: Is the value proposition going forward—going to continue to be as good? And we recently held a conference where Ralph Wanger, one of the most distinguished portfolio managers of the last two decades, spoke and said flat out that the value proposition for the mutual fund industry of a five and half percent load and a one and half percent expense ratio—not to mention the other costs that Jack referred to—was no longer compelling. That's something that the industry is going to have to deal with.

Now Paul raised a great point. Collectively, assets are flowing in an intelligent fashion. They're going to those fund groups that have offered a better value proposition, such as American Funds, Fidelity, Vanguard and others. The question we've got to ask is: Through better disclosure could you accel-

erate that or make sure that the playing field remains as level as possible given the central position that mutual funds occupy in this country today?

One thing, I think it's interesting how you phrased this question: Are fees too high? The only other thing that we talk about the same way is: Are taxes too high? And you can have all kinds of debate there. The one big difference between taxes and mutual fund fees is, while they are both calculated as a percentage of the income that you make or of the assets you have under management, that for your taxes you actually get a bill in dollars. Let's say at the end of year, here's what you spent and that helps to inform the debate over whether these fees are too high or too low. We don't have that same level of disclosure or ease of comparability in the mutual fund industry that we have in taxes or frankly in any other professional service.

PROFESSOR SIRRI:

Mercer, you asked the question: Are fees too high? I think you have to ask compared to what? Are they too high compared to what investors would do if there were no funds? That's one way to look at. Are they too high in a sense that, say, advisors are making too much money? Two ways to think about the question whether fees are too high or not. I think this is really a proxy for what some folks believe is another way of saying that investors are insufficiently price sensitive. People have this belief; certain parties in this debate have a belief that individual investors aren't behaving in a price sensitive manner as much as some would like. I don't know whether that's true or not, but if that's the way people are thinking about the problem then you have to think carefully about what it is exactly a fund is giving you.

Most of you out there in the audience who buy funds, first thing you ask is: What's the performance of the fund that I'm thinking of buying or I bought? Interesting thing about this business is the greatest thing that these funds deliver isn't performance. In fact, there's a lot of academic data to say that performance delivered by your fund in terms of return isn't its outstanding feature. Its real features are liquidity and diversification. That's something that funds give you. So I think what

this debate comes back down to when you think about the fee question that Mercer posed is: What do you want to do about the fact that the people are insufficiently price sensitive? Do you want to act *in loco parentis*? Do you want someone saying: I'm going to take care of this problem for you and make this industry behave as if consumers were more price sensitive?

One fact: You want to approach this differently and say, I want to cause people to think in a more price-sensitive manner by perhaps producing information or otherwise making it easier for them to comparison shop. I think those are two very different approaches to this fee question. I actually think the fee question is a question of consumer shopping.

PROFESSOR BULLARD:

Mr. Tyle, what do you think of those comments?

MR. TYLE:

I think it's very important to keep various facts in mind when you're analyzing this question. I think one issue which Erik, and to some extent, Don touched upon is comparability. It is very hard to ask the question: Are fees too high in a vacuum? And I will point out that although mutual fund and mutual fund companies compete against one another, they are not the only choice out there for the investing public. There are other types of products out there: Hedge funds, separate accounts, etc. which are sold to the most sophisticated and what one would assume the most price sensitive customers.

The fact of the matter is by any comparison, mutual funds are far, far cheaper than those products. In addition, different mutual fund fees—I think Jack Bogle touched on this—pay for different services. They pay for management of the fund's portfolio; they also pay for other services. In many cases it is through the fees assessed by the fund that the investor is paying his or her financial intermediary, a broker-dealer, a financial planner, etc.

When you aggregate all those expenses and you look at the total cost that an investor pays, every study that has examined it has concluded over the last twenty years that those costs have come down and have come down dramatically. Barbara Roper made the point about products being competed; competition to be sold which acts as a driver to cause costs to

go up. In fact, at least in this case, we've seen the opposite. If you look at distribution costs, the costs that are going to the financial intermediaries, those costs have come down the most dramatically over the last twenty years. I think it is very important to keep those facts in mind.

MS. RICH:

Just building on a couple of things that both Erik Sirri and Craig Tyle said. First, with respect to Craig's last comment, there actually are studies that show that for equity mutual funds those costs have increased over recent years. In 2000 the GAO did one study, in 2003 they did another, and both of those studies they found that the costs increased. But more to the point, I think Eric makes an excellent point: How price sensitive are mutual fund investors? I think they actually are price sensitive when they have the information. Some studies have shown that when investors have a choice to choose between no load versus load funds, they tend to gravitate towards no load. That's because they know that no load means they are not paying something.

With respect to the other expenses that they pay, which is to say the expense ratio, that's not so transparent because investors don't really buy funds based on fees; they buy based on performance. And I think if you get better information to investors so that they would understand what the implications of those expense ratio fees were, as opposed to the no load versus load question, you would see better price sensitivity.

MR. ROGERS:

I guess I would just like to address what I think sometimes gets to be two misperceptions. One is this recent issue, the talk about performance. People do choose funds for performance, and performance does include fees, the basic fees for managing the funds and all the other expenses that are there. And so people have a chance at the end of the day to be able to choose funds that include the costs that are implicit in the overall performance. The second issue is what Jack often talks about. I've read about this, and we have talked about it today, but you sort of seemed shocked that overall money managers' total performance doesn't out perform the overall indexes when you include fees.

Well, as you know one of the famous professors at Princeton, Burton Malkiel, a very well-known Vanguard director, wrote a book called *A Random Walk Down Wall Street* where he talks about how efficient the stock market is and how overall all of the fund families together are going to have average performance if markets are efficient. If you look, there are going to be winners, and there are going to be losers; the overall market's going to reflect all the decisions by all the fund managers throughout the country.

And so, therefore, when you add expenses to it, there shouldn't be a shock that the overall returns are going to be less than the overall average market because the average market doesn't include fees. And so I think it is very important to have that issue of efficient markets on the table, and we shouldn't be surprised and shocked that overall you're going to have the amount of fees to be included in the performance.

PROFESSOR SIRRI:

I just want to follow up on a point that Mr. Rogers made which I think is a good one. He points out that expenses, costs of your fund, however you choose to measure them, they get nicked against your bottom line performance. And that's an absolutely true statement. But fee disclosure becomes important above and beyond that for a very important reason: That's that fund returns are so noisy; they're so volatile that you as an outsider cannot tell a high cost from a low cost fund by just looking at its return series. What I'm telling you is that you take two growth funds, two large cap growth funds, put them side by side, make one have twenty basis points higher expense ratio than the other. I will tell you statistically—I won't bore you with the statistics—it would take you decades to tell which one of those had the higher expense ratio. The reason is fund returns are that noisy, which just comes back to the point that getting this information out there is really very important.

COMMISSIONER GOLDSCHMID:

Yes, let me come back to that information point. I guess I will start that I am more or less a generalist at the table somewhat in disguise. Start with the fact that ninety million

plus Americans invest, and there are people to interpret what they're investing in and investment advisors. But you want to make sure that disclosure works here for people who are doing this for family reasons and on their own. And this is an enormously complex product in terms of mutual funds.

It's complex because of the fees and the expenses and the variations on all of that. So you can't simply say, "let the market decide—somehow get disclosure out." Disclosure has been inadequate in the past, and I think one of the things the Commission has to do, and is clearly doing, is providing much better disclosure to consumers than we've had—but that's not going to be good enough. You're going to have to have someone working and that's why governance is so important—working to protect the average shareholder, the average investor at the fund. And so those independent directors, the watchdogs as the Supreme Court has put it, have to be far more effective and active than they've been in the past. Now you add good disclosure and full disclosure and an active board protecting investors, and then you have the competition that Paul is pointing to. That may well work to keep fees in line. But as to how that debate comes out if the high and low, what you need is a structure that's really going to work here to protect investors.

MR. BOGLE:

Let me echo what Commissioner Goldschmid said, but let me just remind everybody that there's not one word, not one scintilla of a thought in the Investment Company Act of 1940 that says that mutual fund costs should be determined by free markets or by competition or by what traffic will bear. What does the Act say? The Act says, "mutual funds must be organized, operated, and managed"—a direct quote—"in the interest of their shareholders and not in the interest of their investment advisors and distributors." And that's what the law says, and that's where we are failing. We have in mutual fund America and corporate America moved from a system of owners' capitalism to a system of managers' capitalism. And in the mutual fund industry, it's a little bit worse. We've actually institutionalized managers' capitalism because the managers control the funds. The directors are very weak, and they need

to be empowered as the Commissioner has just said.
MS. ROPER:

To me what's shocking about Jack's numbers are not—everyone knows that you will under perform the market somewhat. But you said what: 114,000 versus 62?
MR. BOGLE:

61.
MS. ROPER:

61. That's a lot. I mean—
MR. ROGERS:

That's inaccurate.
MR. BOGLE:

Well, the worst of it is the average investor does much worse than that because we always sell them the wrong funds at the wrong time.
MR. ROGERS:

It all depends on the timing of when you look at this. You can find in our industry that you can pick certain time periods and get numbers that will show just about anything. There's no way that over a market cycle that you'd have the kind of under performance you've talked about. In the most recent three-year period, and the last year in particular, you've been able to see lots and lots of funds actually out perform the index over the most recent period. But over a market cycle, you would expect there to be very even—because it's the accumulation of all the managers together—even if you wanted to, you couldn't find a way for them to out perform to the level, the massive level that we've talked about.

So it's like sports—if you look at a sports league, the Yankees might win, and the Cubs usually lose. I'm from Chicago. If you add up the total wins and losses of all the teams, you're going to end up—they're going to be even. That's just the way the math works, and that's the way the math works in this industry. That's what all the economists say, and that's what Professor Malkiel talks about so eloquently in his book that's been reprinted, I think now, seven times.
PROFESSOR BULLARD:

Mr. Haaga, why don't you give some comments and then maybe we can move to Mr. Roye and you can give us your

comments and then maybe give us an idea of what's going on in this area. It's not a static area. I think we have some pending SEC proposals. So Mr. Haaga and then Mr. Roye.

MR. HAAGA:

I think we ought to be careful about how we define performance or investment result as we like to call it. Everybody compares it to the S&P 500. Most equity mutual funds, sixty or seventy percent of them, beat the S&P 500 last year. Don't applaud. The reason we beat them was because the dollar declined and because small caps out performed large caps and the S&P is heavily weighted in its measurement toward large caps. That's the same reason that weighting for calculating the S&P is the same reason we didn't beat them in '97, '98 and '99. Many funds, particularly many of our funds, don't seek to beat the S&P 500; they seek more stability than the S&P 500 and, importantly, more income than the S&P 500. When we're thinking about people's experiences in funds, we always talk about long-term point-to-point total return as though everybody was twenty-five years old. I deal with a lot of octogenarians from church who are taking money out of funds and volatility just ruins them and lack of income ruins them. So just remember that when you're saying don't beat the market, market is S&P 500, it ignores international funds, ignores small cap, ignores income, ignores stability, ignores a lot of things that are important to investors.

One last thing, I was so busy jumping on Jack's comments that I forget to thank Mercer for putting this together. He organized it a very long time ago. This is a group of people who talks at each other through the press and rarely talks to each other, and I'm very excited about the opportunity, and I think it's a reflection of Mercer's standing not only in the industry but also personally with each of us that flew down here to be with him. So thank you for doing this, Mercer.

PROFESSOR BULLARD:

I appreciate that. Mr. Roye, what's going on at the Commission? What are your thoughts on this issue?

MR. ROYE:

Well, let me first say since one of my bosses is here that I have to do the standard SEC disclaimer. These are my views,

not necessarily the views of Commissioner Goldschmid or the other commissioners.

COMMISSIONER GOLDSCHMID:

And the other way around.

MR. ROYE:

So I hesitate to disagree with anything he says, but I think the important point is that—and I disagree with Jack a little bit here—I think fortunately for everybody in this room, Congress did not put the Commission in the position of being an arbiter of the appropriate level of fees. It didn't put the Commission in a position of being like a utility commission in Mississippi setting your electric rates or gas rates, the rates that you pay. And I think the statute does implicitly contemplate that the marketplace should work here. What the statute does is put in place procedural protections and safeguards, as Commissioner Goldschmid alluded to, in terms of shareholders weighing in on fee increases, directors having to approve fees and then the appropriate disclosures.

And so what we've been trying to do at the Commission is focus on those two prongs. What can we do to energize independent directors and have them focus on important issues like fees, and for that matter to deal with some of the problems that we encountered with the recent scandals: market timing and late trading. How can we improve compliance; how can we improve oversight generally in the industry? The statute places the independent directors, as Commissioner Goldschmid indicated, as watchdogs to protect shareholder interests.

So, consequently, over the last few years, the Commission has been trying to strengthen the role of independent directors in the fund framework. We had a series of proposals—and actually Mercer was involved in this when he was at the Commission—trying to increase the percentage of independent directors; we thought that was important. We moved from forty percent to a majority through SEC rulemaking. The Commission has outstanding proposals now that would increase the percentage of independent directors from a majority to seventy-five percent of the board being independent, calling for an independent chairman of the fund board to be in place,

to lead the discussion, set the agenda and to put the board in a position where it's led by someone who's in a position to negotiate on behalf of investors with regard to fee levels.

Indeed, we have an organization of mutual fund directors who are out there working on a set of best practices in this very area so that they know what types of information they should be asking for and that they approach this issue as a negotiation.

So we have a series of proposals in place trying to focus on independent directors and then an issue of improving disclosures. If you go to your fund prospectus, you see there's a fee table up front in the prospectus that lays out the fees; it has an example of what those fees are going to cost you over various points in time. We've got mutual fund cost calculators on our website so you can compare different funds, different classes of shares and see what the impact of those expenses are. We did a proposal on after-tax performance to show you the impact of taxes on your return, so you have that information. And taxes can be a significant cost.

And we're moving into other areas like quantification of transaction costs, which the study I guess that was released today and as some of the co-sponsors of the conference point out, show how substantial those costs can be. How can we quantify those transaction costs so investors have a better sense of what those costs are and how they translate into the bottom line performance? And we have a proposal outstanding to enhance break point disclosures; we've seen failures of the brokers not letting investors understand what those break points are and when they are entitled to those break points.

You're going to see the Commission next month consider a dollars and cents cost proposal, an adoption requiring a shareholder report that translates expense ratios into a dollars and cents number that investors can use, and also additional information so you can take that information and compare it from one fund to another. And then finally—and this may get ahead of where we're going—but we're looking at improved disclosures by broker-dealers not only at when you receive a confirmation but at point of sale. Understanding what the broker's getting paid, the nature of the payments, breaking

those again down to dollars and cents kind of numbers and then moving toward what is a new approach for the Commission, which is again trying to show comparative numbers and ranges and where those numbers stack up vis-à-vis what others charge in the industry as an average. So we're trying to move toward improved disclosure.

PROFESSOR BULLARD:

Thank you, Mr. Roye. Are you sure you don't have any others?

MR. ROYE:

Did I miss anything?

COMMISSIONER GOLDSCHMID

Well, there's a March segment, but we'll—

PROFESSOR BULLARD:

Thank you for putting a pretty concrete face on this issue of regulation of funds fees. We will deal with distribution later this morning. Mr. Barbash, did you want to comment on that?

MR. BARBASH:

Paul hit a lot of the issues to which I was going to refer. It's important to remember in this area that there is a law — there is a federal statute that deals with the mutual fund area. It's one of the highly-regulated areas around. I've read that law; I've read all of it, and Paul's correct in terms of some of the fundamental principles. One is the SEC is not charged with setting rates—never was part of the statute, never will be part of the statute. It was just a philosophical determination that was made by Congress that we don't want rates to be charged; we don't want fees to be set by the government. That's clearly in the statute.

The statute does provide for independent directors. Now Paul made mention of independent directors in a position of negotiating. I would argue that. I think the statute is clear that it's not a negotiation process; it's an oversight process which I think is more than splitting of hairs. It's not a situation where independent directors are coming in as if it was a collective bargaining agreement or some kind of arrangement like that. It's a situation where the independent directors are asked to look over the process, look over the fee, look at the situation to see whether conflicts of interest exist, look at the

fee arrangement, make sure that the fee arrangement is within a band of reasonableness, and, if it is, then approve the fee. If it's not, then reject the fee. I find sometimes that the discussion of independent directors is somewhat unfair. Independent directors oftentimes in the press and in commentary are criticized for not getting the lowest fees. Well, they don't have to get the lowest fees under the law. So they should be measured by what they're doing given what their standard is that they need to meet.

PROFESSOR BULLARD

Mr. Barbash, you pointed out that the law doesn't regulate the amount of advisory fees, but the National Association of Securities Dealers, of course, puts substantive limits on front end loads, on commissions. Maybe you could help us understand that and compare that situation.

MR. BARBASH:

Well, there are a number of regulators that are involved in the mutual fund area, and the principal regulator is the Securities and Exchange Commission which oversees the operation of mutual funds and other registered investment companies. The NASD as the self-regulator of broker-dealers and financial intermediaries and sellers of products can come up with its own rules with respect to the selling of mutual fund shares, and it has.

So the NASD has put into place caps on sales charges, front end, also has effectively set caps on 12b-1 fees, looking at those fees in some respects as a type of load as well. That reflects a little bit different regulatory philosophy. The self-regulator oftentimes can go out and reflect a decision among the regulated entities, among the broker-dealers, if there should be some number. And that's what the NASD has done in this area. The difference—there's also a difference between the regulated entities here—broker-dealer doesn't stand in exactly the same sort of fiduciary duty and doesn't have the same sort of fiduciary duty that investment-advisor has. So the theory of regulation is that in the broker-dealer area it may be better to set certain limits. You're not dealing with an overall fiduciary standard; whereas, the Investment Company Act has built within it a fiduciary standard which is designed

to act as some type of moderator of fees.

PROFESSOR BULLARD:

That's really helpful, Mr. Barbash. Why don't we—it's a great issue. Why don't we close out fees with Mr. Bogle, Commissioner Goldschmid and Ms. Roper. And then I hope we can move on to talk about the role of the board which you mentioned.

MR. BOGLE:

Just very briefly. The wisdom of Warren Buffet might be helpful here. Two comments. When we talk about the chairman of the fund negotiating with the chairman of the management company when they're the same person. And Warren's comment is, "Negotiating with one's self seldom produces a barroom brawl." Think about that one and think also about Warren's comment that the '40 Act intended for the directors to be dobermans, and they turned out to be cocker spaniels. And I think Barry has just expressed in his earlier remarks the kind of cocker spaniel theory of mutual fund directorship with which I do not want to be associated. I'm a doberman guy.

COMMISSIONER GOLDSCHMID:

Yes. Let me pick up on the government setting fees aspect. Clearly it's indicated that if you have monopoly power—and this is wearing my academic and Columbia antitrust hat. If you have monopoly power, you need a government who sets fees. Absent monopoly power, from 1940 on we've learned a great deal: be very careful about government setting fees in competitive markets. In 1975 we got rid of it for broker-dealers. We got rid of it for surface transportation; we got rid of it for ground transportation. All of that makes sense. And that's why setting up the structure to get the right kind of fees and expenses is really what makes sense here.

But let me react to Barry much as John did—John Bogle. The 1940 Act is a long time ago. Congress has seldom come back to these acts. They can grow and change. Whatever Congress was thinking in 1940, the role of directors must be a far more serious role today than it has been in the past. That's absolutely critical. And we continue to use the word "fiduciary" for directors—utmost good faith and loyalty. They've got to

carry that out on a serious level or this wonderful product will not work in the long run.

MS. ROPER:

Yes. I would just point out I agree with everything you've said about boards. There is a difference between setting fees and policing fees. And it's my understanding that the SEC actually went to Congress about thirty years ago and requested the ability to ensure that fees are reasonable but has proved to be extremely reluctant to then use that authority. And when you have a government that has the power to take action against managers or boards if fees are not reasonable, and they don't use it—it sends a message that this is really pretty much okay with us. So an S&P 500 index fund with a 2.18% expense ratio when Vanguard or Fidelity can do it for 0.18% or 0.19%, it's fine; that's not unreasonable. We don't want them setting fees, but you do want them policing the outliers. And then I agree an independent board that takes seriously its responsibility to ensure that the fund is operating in shareholders' best interest gets very vigorously involved in the debate about what is an appropriate level, what the costs are and what an appropriate level for these fees are.

PROFESSOR BULLARD:

Well, I'd like to continue this fee discussion, but maybe if we could start to bring in more specifically the role of the board in setting fees. They're the ones that actually sign the advisory contract, not the shareholder. So maybe, Professor Sirri, you can start us off moving in that direction.

PROFESSOR SIRRI:

I think in some ways it's interesting and all that price as a discussion comes up as much as it does here. When you think about this industry and you think about this business, it's highly competitive by all the indicia that we normally have about businesses. You have hundreds and hundreds of advisors. You have thousands of funds. And then you put at the center of this, a board that has a duty with respect to the approval of advisory fees. I think regardless of what kind of pressures you want to bring to bear on this process, I think it's—and I will come back to a point I made earlier—it's important to remember that in the end our best remedy here is

an informed consumer.

If you go to the drugstore, you can look at and you can go shopping for ibuprofen. You know Motrin costs a lot more than plain-wrapped ibuprofen, but they're both up there on the shelf. They're the same product chemically, you know. There are some people who will know the difference and will pay thirty percent less to pick up that plain-wrapped ibuprofen. There are others who will prefer Motrin. Now, I think in some sense we've got to ask ourselves how we feel about that. Clearly, medicine is an important thing.

There's an element of that working here. Barbara brings up an important point in that you do see a lot of dispersion around prices. Plain generic products have a lot of spread, but again to come back and put excessive pressure I think or an excessive amount of responsibility on directors there for the approval of those contracts, it's not that it's a bad thing to do, but I think there's a much better remedy here. I think the best remedy's the market.

MR. BARBASH:

Well, I think I would defer to Paul because I think he had a point to make. My only—a couple of specific things. First of all, in terms of the Investment Company Act staying stagnant since 1940, I think that's not really the case. It's been looked at in 1970 Act amendments, 1980, 1996; it was subject to a very comprehensive review. I'm not suggesting the law or the regulation should be stagnant; all I was suggesting was when you look at how a particular set of individuals act, and you're measuring against the standard, you have to use the standard that the law provides.

MR. TYLE:

I think in looking at the board's role with respect to a mutual fund, and in particular the board's role with respect to fees, we need to take a step back and understand that corporate governance for a mutual fund is in very important respects different than corporate governance for a standard operating company. At bottom, you have to think, what is a mutual fund? A mutual fund is a mechanism by which an investment advisory firm—a Capital Research and Management, a T. Rowe Price, an Ariel Capital offers their servic-

es—as Eric said earlier to offer a diversified, liquid, often professionally managed portfolio to the investing public. That fund has been started by that investment advisor. Like any other business in America, that investment advisor is trying to earn a reasonable profit, a reasonable return on its capital.

A fund is not a freestanding entity that just happened to have several million dollars sitting in the bank and has a board that one day scratches their head and says, "Gee, I'm going to hire Paul Haaga to manage the money or maybe I'll hire John Rogers to manage the money." It has been started by that investment advisory firm. That firm sets a price for that. We've talked about the various components of that price. Clearly that price has to be transparent so investors can make reasonable choices. But even on top of that you have a whole panoply of additional controls on fees in the mutual fund context.

If the advisor wants to raise that price, the directors have to approve that. The directors who are independent of the management company must separately approve it, and then it's going to go, it has to go out, to a vote of shareholders, and they have to approve it. And you have to think again, a mutual fund is what, in many respects, like any other financial product an investor can purchase. No other product do consumers have that control and do you have an independent body of people watching out for those consumers. If my bank wants to raise its ATM fees, it wants to raise the fees charged to the checking account, there's no body of independent people that's going to sit in judgment on that, and they sure are not going to send out a ballot to me so that I can vote yeah or nay whether I want those fees to go up. You have all of that in the mutual fund context.

Just to summarize: The directors have an important role, but it is not a *de novo* setting-the-fee role. It is to act as an additional check to make sure the fees fall within a reasonable band. It's also if you look back at the history of the 1970 amendments that gave directors additional responsibilities for mutual fund fees, it was to make sure that as circumstances changed, those fees could be reexamined. And what Congress was particularly concerned about, as a fund grows and realiz-

es economies of scale that those are being passed on to investors, and that is in fact what has happened.

MR. ROYE:

I guess I would disagree with Craig and Barry a little bit. I think that as Harvey and Jack have indicated you can go back to the preamble of the statute where it says the funds ought to be operated in the interest of investors. And I think that when you look at fees and expenses that it reduces returns to investors. And I think directors do have an obligation to understand the cost, understand the profitability of the advisor, and indeed the court cases say this. And look at whether or not economies of scale are being realized and whether or not some of those benefits are being passed on to the benefit of the investors in the fund.

You see some people and Warren Buffet saying, "Well, directors ought to be firing managers." But I think that directors, in some cases, they do need to fire the managers, and, indeed, they have. But I think directors need to focus on the fee issue. It's an important issue and may be the most important issue that they have responsibility for. And that's not to say that they should be looking for absolutely the lowest price because it depends on the nature and the quality of services and the value that is being produced for the investors. I guess this notion that directors are there just to sort of rubber stamp what the management company serves up, I guess I have difficulty with that given what the statute says.

MR. ROGERS:

You can try and add some real color. As an entrepreneur, I started my company twenty-one years ago when I was twenty-four years old, and today when we go into a mutual fund board meeting, it's the independent directors who determine what our management fees are going to be. We're not even in the room when discussion occurs around our fees. And we use independent counsel to help the directors make the decision on whether to renew our contract that year. We use independent services like Morningstar and Lipper Analytics where we look at all the competition and what the fees are to make sure that our directors are making those decisions with all the available information.

So this notion that somehow the chairman of the board is negotiating with itself really is something that is not correct in this day and age where again the independent directors make the final decision on whether the investment advisory contract is going to be renewed.

MR. HAAGA:

I'd caution everybody that Warren Buffet is very rich, but that doesn't make him well informed on all topics. I would worry about what he'd said if he ever attempted a mutual fund board meeting, but fortunately he has not. One of the things that has pained me the most in reading about some of the characterizations is knowing the independent directors of our groups of funds as well as I do. That's really how I spend my time is in a lot of board meetings, a lot of committee meetings, audit committees and others, and then trying to match that up with this characterization. I would just admonish you to look at who these people are—they are former CEOs, current CEOs of businesses, they are business school deans, they are college presidents. Somehow the idea that these extremely important, extremely successful people come into the mutual fund board meeting, and all of a sudden for that half day become lap dogs, asleep in a puddle of drool, it doesn't comport with reality. That's not what happens.

While we're talking here about setting fees and fees is an important thing, but they do a lot more than that. They're also very responsible for the investment results of the funds, the services that are provided, all of ours own shares in the funds. When there's a mistake in their account or somebody on the phone isn't good, we hear about it very quickly. There's an awful lot of oversight we've been putting on our boards lately. We've been asked to do presentations on succession planning. They want to make sure whatever they are paying us is not just being consumed on toys, but we are using it to build up our organization for the future and we've thought about things.

Finally, I'm going to object to the measure of effectiveness that is often used which is how many times does a board fire a management company? That's like I've compared it to measuring the effectiveness of the defense of a basketball team by

only counting blocked shots—not looking at shots not taken, not looking at anything else that happened on the floor. Rarely does a board fire a manager. It's important that they have the ability to do that. When I say manager, I mean management company. Frequently a board will ask enough questions about the results of the fund and what we the advisor are going to do about them, that the individual portfolio counselor gets rotated off. There is movement, there is change and there is a result that doesn't show up in the statistics. One other thing: Look at the number of mergers. There are a lot of mergers in the fund industry. And I'm aware that many of those—not all of them, but many of those—have taken place because the boards have come in, the two groups we merged with back in the seventies, the independent directors we were working with said, "We are not going to embarrass you by firing you, go find a merger partner," and they came and found us. So be careful about those measurements too.

PROFESSOR BULLARD:

Mr. Haaga. Your regulator wants to go next, so I think we better defer to him.

COMMISSIONER GOLDSCHMID:

Well, I agree with much of what Paul said, but let me put my own spin on it. One, this is a business based on trust. It's grown into a seven-plus trillion dollar business in twenty years basically because of trust, and everyone has got to keep that in mind. That makes the board more important in this area than the traditional public operating corporation. This is a business tricked up with conflicts between the investment managers and the fund itself. Now the most responsible will be good people; the dangers here are very real. So from the SEC standpoint, the question was how do you make that board more effective? Now, Paul has got some very good people. As long as you have seventy-five percent plus, we're assuming that will create a critical mix that will allow that board to function well. The chairman of that board, or chairwoman, is critically important. There's no way of avoiding that he or she will deal with people, will set agendas, will guide discussions and is in a position people are invariably looking to lead. You don't want the fund manager in that position

given all of the potential conflicts, and that's why because the other key to making these boards work is getting information. Paul Roye worked out a terrific compliance officer system of reporting up. Lawyers are now required to report up; accountants are in that same position. Getting adequate information to those independent directors, and the system will go far—it's working.

MR. PHILLIPS:

I think Paul made an interesting comment when he said you look at the people who are doing these. Well, the industry has made it pretty hard to look at the people who are in these roles of independent directors. That information is typically relegated to the statement of additional information, really truly buried. Unfortunately, it's a real black eye for the fund industry yesterday where a *Wall Street Journal* reporter tracked down a number of independent directors, showed the huge number of funds they are working on and that collectively they had none of their own money invested in these funds. I think we've got to bring more visibility to the boards. And one thing that everyone seems to be in agreement is the theoretical check of having to go to the boards and the fact that they might say no; it really has benefited this industry.

And we track funds in other parts of the world where you don't have the corporate structure, and their costs are much higher. In the end, the investment proposition to the investor is much worse. So there's something very good about boards, but it seems to me we've got to create more visibility for boards. One of the things we've advanced is having the board report in the annual report each year to shareholders just a one-paragraph summary: Here's what we did for you this year; these are the things that we looked at; these are the actions that we took. You've got to create that accountability. You've also got to put the identity of the independent directors and a way for the shareholders to communicate to them front and center in the prospectus. It's a really valuable check on management.

Everyone here agrees with that, but if it's invisible, if people don't see that, if board directors don't have that connection to shareholders, it's not going to serve the purpose that it

should. Unlike Warren Buffet, perhaps, I have sat in on mutual fund board meetings and shareholder meetings at the invitation of some fund complexes. One of the things that I've seen is you very quickly see the independent directors saying "we" meaning "us" the management company and not "we" the shareholders. It's sort of like the Stockholm syndrome. You know, they spend all of their time with the management company and not with the shareholders. You can't represent shareholders' interest if you're not in contact with them. We've got to establish that link.

MS. RICH:

I just want to put a plug in here for my bosses because a lot of the things people are talking about, were really the premise of HR 2420, the Mutual Funds Integrity and Fee Transparency Act that Richard Baker introduced back in June. The premise of that legislation was to help investors through two prongs: One, transparency which we talked a lot about competition and how we could better inform investors about fees. Number two, corporate governance. Richard Baker remains committed to the provision that ultimately was not included in the bill that passed the House in November. He felt it vitally important to include a requirement that the chairman of mutual funds be independent because of the fact that as Craig Tyle pointed out, the corporate structure of the mutual fund is very different from an operating company. Only in a mutual fund do you have a pool of money that is governed by a board of directors that if you have interested directors, those directors have an allegiance to the management company which stands to profit at the expense of the beneficiaries of that pooled money. Because of that dichotomy and that conflict of interest that does not exist in an operating company, it was vitally important to Richard Baker that there be an enhanced role for the independent directors, in particular the role for the chairman, that he be independent.

MR. BOGLE:

First, let me just say that, editorially I banned the use of the word "product" at Vanguard years ago because I don't like thinking of mutual funds as a can of Budweiser beer or a tube of Colgate toothpaste or a loaf of Wonder bread. A mutual

fund is not a product, but I welcome those who believe it is because I think they're going to be easy competitors. I want to talk now about the role of mutual fund directors and how they do their job. Let me give you one little piece of evidence. This is anecdotal, but I've looked at hundreds of these.

Now let's look at how the certain fund group dealt with a large growth fund with assets of 2.7 billion dollars. They said to the manager, "We will pay you ninety-seven basis points and give you fees of forty-one million dollars in a particular year." Actually for this fund they paid a half a billion dollars in the previous five years for this fund because it shrunk a lot. Then the directors say, "That's fine." Now let's look how the directors of the California pension fund dealt with the same advisor with about a billion dollars worth of assets. They said, "We will not pay you ninety-seven basis points; we will pay you eight basis points. We will pay you, in fact, seven hundred thousand dollars a year instead of forty-one million." And then they said something else, which ought to be part of this conversation. They said, "We know it's not too much. But if you do a good performance job, we will give you a lot more money; we'll give you an incentive fee if you do what you promise to do and that is help us get good returns." The funds do not do that; fund directors don't do incentive fees,.

There are only, I think, only five firms in the industry that use incentive fees, which are so clearly linking the interest of fund investors to the interest of fund managers and the interest of fund investors. But the industry does not do it because it's hard to earn the incentive fees. As John said, we all lose by the amount of their costs which is a truism. So the directors ought to do as good a job as California does.

COMMISSIONER GOLDSCHMID:

Jack, you've been in boardrooms?

MR. BOGLE:

I've been in a few in my day.

MR. BARBASH:

In terms of the incentive fee, I think that Jack makes a good point about incentive fees. One of reasons why there isn't that much use of incentive fees in the fund area is that the '40 Act doesn't have very much room for the kinds of incentive

fees. It may be a public policy idea to think about expanding that and giving greater flexibility to fund companies to come up with different types of fee arrangements. That's been working out there for some time. There's a lot of folks out there who look at hedge funds and say that the ability to have performance gets you the ability to have a better fee structure. And we don't have that in the mutual fund area.

MR. ROYE:

I was going to make several points quickly and one relates to the fact that it doesn't really involve the fund groups here. Oftentimes when we go and do examinations of mutual funds and look at directors' determination about the fees, we can't figure out what they looked at or what information they had to base that decision on. So one of the initiatives that the Commission proposed was a recordkeeping requirement to require all the information that directors use to make the decision on renewing the advisory contract to preserve that information so that we could go in and look at it. I think it also may have the by-product of having directors think about what information they need and focus on it.

Indeed, the statute already creates an obligation, but we've seen, particularly some of the smaller fund groups, we can't figure out how the decision is made. But we still can't make out a case that the fees are excessive because the fees aren't out of line with what you see elsewhere in the industry. So if you look at standards the courts have set, we can't make that kind of case.

Second point is kind of a merging of the disclosure and the role of board. Chairman Donaldson has announced—you're going to see this next month—the Commission is going to propose that directors, and this goes to Don's point as well—that directors explain in the shareholder reports how they arrived at the decision that the fees were fair. And to force that disclosure and hopefully get to disclosure that's beyond boiler plate getting to some of the issues that Jack raised about: What did you look at? Did you look at what was being charged to a pension plan for the same service as other funds that are managed by the same advisor to see if we can force some better disclosure in the area?

And finally, the point that Don made about director disclosure generally. That information is in the statement of additional information that investors have access to. A judgment was made—and maybe it was the wrong judgment—that information ought to be disclosed. Do directors own shares of the fund they oversee? It was put in the statement of additional information because a judgment was made that most investors would not be interested in some cases, and even in who the directors are because they are focused on information like performance, fees and expenses. But we wanted the information out there for the very reason that you saw the article being published about directors not owning shares, not having skin in the game.

PROFESSOR BULLARD:

Commissioner Goldschmid, you wanted to make sure you had an opportunity and Mr. Roye, to present where the Commission is on the independent director proposals. Do you think we've covered that enough or would you like to go through those and talk about them?

COMMISSIONER GOLDSCHMID:

No, I think we've really gone through it. We proposed them seventy-five percent at least: an independent chair, all of the reporting up mechanisms, the ability of the board to have outside experts when they need it. All of that is proposed and hopefully will be a final rule within a relatively short time.

MR. ROYE:

Let me just add quickly to what Commissioner Goldschmid pointed out. There's fund governance and then there's manager ethics. And another thing the Commissioner did: the Commission proposed a requirement that every management company, every advisor, not just advisors to mutual funds, have a code of ethics that reflects the fiduciary obligations that they have to adhere to, and we put some minimum requirements. Of course, they have to make sure their employees are complying with the federal securities law, and we wanted to deal with some of the issues like managers not reporting trades in their own mutual funds where they may be market timing, but an effort was also made to focus the management companies on their ethical obligations which seem to

have been lost in some of the managers these days.

COMMISSIONER GOLDSCHMID:

And the one other key aspect I'd add to what Paul was talking about is enforcement. People have got to be serious, and we will use the law where fraud has occurred to go after those people and fund directors who are negligent or reckless in important areas. One doesn't want wild litigation, but one does want that incentive to do the right thing.

PROFESSOR SIRRI:

I think you have to applaud the SEC for strengthening the boards. That's a sensible thing to do, but we can do better than being anecdotal here. We can be a little analytical about what you can expect from a strengthened board especially as regards to fees. Someone has done a study to try and look at a very, very simple question: If a board has more independent directors are its fees lower for that fund? And the answer to that question is: Yes, but it's slight. So I think the point there is that strengthened governance may help, but that strengthened governance is not going to be a situation where it brings fees back to the level where, Jack, you would be happy.

MR. BOGLE:

Well, if I could just add one thing here. We know who has the lowest fees in this business, and this is a firm which is called Vanguard. We operate a .26, and we negotiate fees. We go out on the line and negotiate fees, and if we pay less than one basis point for a GNMA fund or four basis points for a Wellington Fund, that's because we go to the advisor and say, "Look, enough already." And the advisor doesn't even argue because the rate of fees is not important. They are getting so many dollars, I honestly don't know what they do with them.

MS. ROPER:

Several people have suggested that the board, in determining whether the fee is reasonable, looks at what the rest of the industry is charging as part of how they make that determination. The problem with that is, if everybody is charging an unreasonable amount, they all look reasonable.

MR. BOGLE:

It's executive compensation all over again.

MS. ROPER:

You have to look beyond what everyone is doing to look at what the cost of the service is and what's a reasonable profit for offering that service to get at a reasonable fee. And I love the recordkeeping requirement—that's great.

MR. PHILLIPS:

I think you want directors who think like shareholders and say is the value proposition good? There are short-term taxable bond funds in the market today that have a five percent load and a one-and-a-half percent expense ratio for an asset class that's returning about five percent. So it's saying, if you'll sacrifice all of the first returns and then about a third of the returns for each year after that, we'll give you exposure to this asset class. No amount of great management can overcome that. That's a situation where the board that has stepped up hopefully because they have their own money in the fund, and says, "This isn't a winning value proposition, let's change it."

MR. ROGERS:

I was just going to add that the value proposition is an important issue. It can't just be on looking at it from a rate of return perspective you talked about. Jack was on the PRINCO Board which is the Princeton Investment Management Company that oversees the billion dollar Princeton endowment. I'm on that board now and arguably they're probably one of the most sophisticated investment managers in the world. You know Princeton, Yale, and Harvard have great returns, and things are going very well. They often go out and hire money managers and pay them roughly higher fees because they see the value added. They see how good that money manager could be or that private equity firm could be or that timberland or real estate firm could be, and they just don't hire managers based upon the rate of return as you've talked about.

Because of the competitive landscape there's an opportunity for choice, and people aren't forced to pick unless—if they're going to pay, they're going to pay up because they perceive value is there.

PROFESSOR BULLARD:

Thank you for those comments on fees and the role of the

fund board. I would like to move on to another topic now. Jack, you actually had kind of a segue with that little marketing pitch for Vanguard. You all have had a lot of other marketing pitches in your relationships with your brokers that you are paying for in the form of fund distribution costs. That has in some respect been the focus of the most heated discussion within the industry as to how to regulate fund distribution. What I'd like to begin with is to start with a pretty broad question about why is it that, particularly in the financial press, we have the presentation of fund distribution, what brokers charge, presented in such a negative way? It's such a pejorative thing in our industry.

So I'd like to get a sense from our panelists starting with Mr. Bogle. What is right or wrong about this generally pejorative view of distribution? Is it an evil? Is it something that we have to live with? Is it a good, how would you characterize it?

MR. BOGLE:

Well, it's a big marketing brokerage distribution, whether you're talking the life insurance industry or any other financial service industry, and it is a dead weight on the returns of investors and the financial service as has been observed earlier. All of the financial service businesses have been built on buying sales power rather than appealing to the buyer. It's a seller-driven system rather than a buyer-driven system.

So the dead weight is expensive, and it drives returns down. The luckiest or the smartest, if you will, thing I ever did was get Vanguard out—that was almost first thing we did after starting Vanguard—got us out of the brokerage business after fifty years in it. So, I know a lot about that business. I was in it for twenty-five years, and it's gotten worse since then. You have to pay up, you've got to pay shelf space to broker-dealers; all kinds of brokerage payments are now made. We used to have reciprocal brokerages—it was even worse in the old days. So you can argue that's better, but it's a dead weight. So to the extent that we can get marketing costs out of the system, we will improve the returns of fund shareholders. That said, I'm the first one to say that a lot of investors need help, and what are the terms and conditions on which they get that help—that's a very important point. And

if you have a good financial advisor that's just keeping you from making mistakes, he's going to be well paid. But I think in the system overall, you the investor are going to be well paid for that cost you are incurring. But overall, marketing costs are destructive.

MR. HAAGA:

At the risk of launching Jack again, if marketing costs are a dead weight, how come Vanguard advertises? You spend a lot of money on advertising.

MR. BOGLE:

Well, I made a big mistake. I should have cut out advertising entirely. We did very little when I was running the place. And when I now do the *New York Times* crossword puzzle and see that four-color ad opposite it on Sunday, I feel the same way you do.

MR. HAAGA:

There are a lot of areas in which we get trapped in vocabulary, and the vocabulary we're trapped in here is "sales." And the assumption is that the only thing that's being paid for with fees that go to the brokerage firm or the advisor, is a sale. People compare it to a sale of a car or a grocery store and shelf space and things like that. I go back to my favorite analogy which is my octogenarian friends that I talk to after church who always come up to me after telling me whether they liked my picture in the paper or not on the fund scandal article, and they will talk about their investments.

Now these are people whose biggest fear in life, other than earthquakes, is outliving their assets. They are not going to earn any more money; they are not going to buy any more shares. They are desperately afraid that they will outlive their assets. They ask me what to do. I always tell them about Vanguard, and I tell them about other funds like ours. I say if you want to do it yourself, you want to go up on the website and do the calculators and figure out how long you're allowed to live given how much you're taking out of your funds, by all means go to Vanguard and you'll save money. But if you need an advisor and you want to sit with, then it's going to cost you money. You have to pay sales charges coming in, and you're going to have to be in a firm like ours that has distribution

slash advisory fees that are paid on an ongoing basis to a broker or advisor. And not surprisingly, all of them opt for the advisor knowing that it costs them extra money, and every time the market moves up or down they go sit with the advisor and spend a couple hours and do nineteen different simulations on the computer that says how long they can live without running out of their money, whether they can start taking more out, whether they have to take less out. I have a hard time sort of squaring my image of my older friends sitting with a broker with the shelf space, one-time sales is bad, every fund ought to be a field-of-dreams fund, just-put-it-out-there-and-they'll-come analogies. I think it all comes from being trapped in vocabulary.

PROFESSOR BULLARD:

Ms. Roper, is that a field of dreams that we think negatively of distribution? What is it really?

MS. ROPER:

The problem I have is even on a panel like this, people treat the words "broker" and "advisor" as if they are interchangeable, and they are not. Brokers, despite calling themselves financial consultants or financial advisors, are sales people. They do not have a legal obligation to put your interest ahead of their own. They certainly don't have a legal obligation to ensure that you get the very best product at the best price. They market themselves to the public as if they did. So you read the ads: "It's advice that's at the heart of our relationship, not sales. Consider your financial consultant more as an advisor than as a stock broker. When you buy a mutual fund from us, you get more than a mutual fund. You get advice."

They're out there marketing themselves to the public as if the nature of the service they offered was advice-driven rather than sales-driven. In fact, legally they are limited to giving advice that is solely incidental or merely secondary to product sales, which is not the service that most people think they're getting when they have paid those enhanced costs. I'm sure there are very good brokers out there giving very good advice, but there are also brokers out there who are selecting the funds that they recommend based on a preferred list that is

driven by how much the broker-dealer gets paid and not by which are the best funds.

There are brokers out there who are selling funds based on whether they individually get paid more to sell those funds, and yet they're portraying themselves to the public in a very different fashion. And I don't think you solve this problem until you get at that huge gap between how they're allowed to present themselves to the public and the legal obligation that they actually have.

PROFESSOR BULLARD:

Thank you, Ms. Roper. It's an interesting twist on the mutual fund issue, the idea that we also need to look at the regulation of the advisors and brokers who are selling you those funds.

MR. PHILLIPS:

What's wrong with this notion 12b-1 being bad? The notion that the advisor doesn't deserve compensation. And whether you're a broker or financial planner, I think the lines are blurring somewhat. Our hosts' groups here represent the cutting edge in financial planning, and frankly a lot of brokerage firms are following suit and increasing their due diligence and there is a suitability standard for a broker selling a fund. But I think what's wrong is this notion that advice should be free. I think people giving good advice deserve to be compensated. What I think is right with the negative opinion about 12b-1 fees is this hugely complicated selection process of a mutual fund. And it allowed the fund industry to create or to carry out something that frankly was unfair. The notion that "B" shares were no-load funds. I've talked to thousands of investors literally who came to me and said, "I bought a no-load fund." And then you ask them what they bought, and they bought the "B" shares of a load fund organization. They thought they were getting something for free.

PROFESSOR BULLARD:

What are "B" shares for our audience?

MR. PHILLIPS:

"B" shares are where you've taken and gotten rid of the upfront sales charge, and what you've done is replaced it with a fee that goes down each year. If you hold for generally more

than five years, you can avoid it entirely but you pay additional 12b-1 fees initially as high as 1.25 percent a year that are now more generally capped at about one percent a year. The thing is if you can stay four, five, ten, fifteen years, you're paying that amount year after year after year. In some cases, they will convert to the A shares, but you end up paying basically the same thing and you think that somehow you've gotten it for free. That I think was unfortunate.

Today you have a whole series of different share classes—A shares, B shares, C shares, D shares, etc. I was talking with a regulator in Washington recently who said, "My heavens, Don, there are a lot of letters left." We have hugely complicated this issue in that the beauty of mutual funds was their simplicity, and I think that's unfortunate. It's focused the public on the cost of financial planning, not on the benefits. And there's another thing that's somewhat insidious that doesn't get discussed much, and that's when you shift this compensation for distribution from a clean, upfront sales charge and you imbed it in the expense ratio. You begin to change the behavior of funds managers. We've seen systematically fund managers that run higher cost funds, driven largely by higher 12b-1 fees, systematically take on more risk than those that are running lower cost funds, and it's perfectly understandable why that's the case. If you're running the lowest cost bond fund in your category, you can just come out and run sort of a plain vanilla fund and get good results. If you're running the higher cost funds and you do the same thing but you have higher cost, you will always trail. Fund managers are competitive. So, if you give them higher costs that are taken against their performance, they'll go out and try to find a way to win the game. They'll take on higher risks. They'll get into lower credit quality. They'll extend maturity.

What we've done has actually done a disservice to the octogenarians that Paul was talking about because we've tempted managers to take risks that perhaps they wouldn't have taken otherwise by shifting the compensation from something that's clean and upfront and imbedding it in the ongoing expenses.

MS. RICH:

First of all, investors should be able to choose if they want advice or not; they should be able to choose if they want to buy a Mercedes or a Toyota. It should be their choice. I think one of the reasons that the whole issue of distribution has gotten this pejorative sense to it is that a lot of the distribution costs are sneakily hidden. When something is being hidden away, it looks like it's a bad thing; people are trying to hide something bad. For example, the revenue-sharing arrangements where brokers were being paid to sell certain mutual funds over others, but the investors had no idea. They thought—like Barbara was suggesting—that they were getting good advice when, in fact, the broker was just selling something for which he was going to get a trip or an extra payment. That is not an upfront relationship to have with your investor—it's not something that the investor can make reasonable decisions without knowing.

So, I think it's very important again to go back to transparency to let investors understand what the incentives are that brokers have to sell certain funds or not. Similarly 12b-1 fees, which are disclosed, nevertheless have changed as being the vehicle of choice to compensate intermediaries from the front-end loads which investors have become more clever at avoiding or more desirous of avoiding.

As a result, 12b-1 fees which are serving effectively the same purpose as a front-end load are not as noticeable as a front-end load because they are imbedded in the structure of the expense ratio. I think transparency would help to eliminate the pejorative sense of distribution because there's nothing wrong with having investors choose to pay for advice, but they just don't realize that they're doing it.

MR. TYLE:

Just two things: first, with respect to Linda's last point about greater disclosure of revenue sharing and other types of incentives, I want to say we could not agree more. We at the mutual fund industry actually called for this sort of disclosure almost ten years ago, and we're pleased that finally the SEC and the NASD are moving ahead with the proposals. So we are square on that the investor has a right to know the incen-

tives that their financial advisor, their broker-dealer, is subject to when they're making a recommendation. You know, I just want to point out that at the end of the day, Rule 12b-1, as it's been used, has given the investors more choices. They can choose to pay an upfront load; they can choose to pay that same cost over time.

I think it's important that we've talked about all the problems. Is it as transparent? It is disclosed in the front of the prospectus. It's going to be part of the new SEC disclosures, both in the shareholder report and part of the confirmation statement. But I think it's important to note that it has advantages as well as disadvantages. And if we're going to contemplate moving away from Rule 12b-1, I think we're going to have to ask ourselves, "Can we give investors the same degree of choice if we take it away? Will there be a loss if they no longer have the choice?" It's been talked about. Don made the point that it's more confusing now with the different classes. Well, that comes with additional choice. And if you're going to reduce the potential confusion, you may be taking away choice. I just want to point out there are factors on both sides the policy makers are going to have to grapple with.

PROFESSOR BULLARD:

Maybe we could get some comments from Commissioner Goldschmid, and then maybe Mr. Roye can, like he did with the fees, put a more concrete face on this issue by talking about, not only just some of the proposals that you briefly mentioned earlier, but also some of the investigations and enforcement matters that relate to the fund distribution practices.

COMMISSIONER GOLDSCHMID:

I just want to take up—it's a much larger topic—but Barbara Roper's comment about how brokers and advisors have come together. They both have stricter rules, stricter than people realize. One is fiduciary and one with suitability and other requirements, but they've come together. They're doing the same thing, and there is a problem for us to think through as to whether we ought to separately regulate and whether there ought to be different rules. Linda Rich's point is very important in terms of the hidden costs. We've lived in a world

now where the broker was getting paid in all kinds of ways with all kinds of incentives and nobody knew it. Some of it was clearly wrongdoing, and Paul picked that up. Some of it was more complex, but that system can't make any sense. I think everybody agrees to that.

The A and B shares, the audience ought to understand clearly, we've had a number of cases—having this number of different shares may be all right in terms of giving consumers choice, but very often the consumers have not at all understood—even wealthy consumers—the differences between load and no-load and A and B and C. And brokers and advisors who have a duty to explain it were not doing so. When that happens again, the SEC has enforcement actions to bring. Paul, you may want to take it from there.

MR. ROYE:

I think I would go back to something that Jack said just in terms of looking at distribution and how it's evolved. 12b-1 was put into place in the 1980s with a certain kind of framework in mind, and it was viewed as maybe a temporary-type solution to the fund industry's net redemption issues. But the rule was framed in a way that essentially allowed 12b-1 to be used and evolved in the way it is today. And I think, as Craig has pointed out, it has facilitated different ways for investors to bear costs and pay for distribution as opposed to front-end loads.

When 12b-1 was put in place, the loads I guess were essentially eight-and-a-half percent to buy into a fund. They're nowhere near that today. They've come down dramatically. It has produced some benefits, but we've seen the NASD put maximum sales load caps in terms of where these loads can be, but we've also seen the caps on 12b-1 fees. We've seen practices evolve to get around these caps in certain circumstances. You've seen the revenue sharing arrangements created. You've seen brokerage being used to facilitate distribution, and these practices have evolved.

We got into looking at this issue, and I know that some people have been critical of the Commission. I heard somebody refer to it as in *Casablanca* where the prefect of the police goes into Rick's club and says, "I'm shutting you down?" Rick

says, "Why are you shutting me down? My God, I'm surprised to find out there is gambling going on in the club." So revenue sharing and the use of brokerage are practices that yes, we've known about, but I think we went in and started looking at what was really going on and what was really disclosed and we did see some things that surprised us. We saw in some cases really no disclosure; the fees and arrangements were going on and again investors were not understanding it. With brokers clearly having an obligation under 10b-10 to make that kind of disclosure, and then we saw brokers relying on the disclosures in the fund prospectus to accomplish that disclosure to investors.

The funds prospectuses having generalized disclosure about revenue sharing payments, but guess what, there weren't revenue sharing payments being made. The advisor was not taking money out of its own pocket to encourage distribution or facilitate distribution. It was using the fund's brokerage commissions in explicit arrangements to facilitate distribution which raised issues about disclosure, compliance with the NASD rules. You've seen at least one enforcement action against Morgan Stanley so far in this area. And we're looking at the other situations.

So where this brings us to is what the Commission recently proposed, along with the NASD proposal requirements for when you open an account, when you first purchase mutual fund shares and for revenue sharing disclosure, whether or not the broker is getting differential compensation. The Commission proposed, and you'll hopefully see in the release in the next few days on the Commission's website, a requirement that the confirmations that you get when you buy fund shares, lay out the sales load, 12b-1 fees, these differential compensation arrangements and revenue sharing payments are all brought down not only to percentages but quantified into dollars.

PROFESSOR BULLARD:

Is that going to be one dollar amount or is it going to be one dollar amount for each of the six or seven?

MR. ROYE:

We're going try to get to dollar amounts in each category

and then point of sale disclosure, which is a novel approach for the Commission requiring that before you make the investment decision that you get information about what the sales loads are: front end, back end and the nature of the asset base sales charges. Is my broker getting paid more for recommending this fund versus alternatives? What other kind of payment is the broker getting paid and receiving for making that recommendation?

MR. BARBASH:

As you look at this whole area, what strikes me is that this industry is absolutely not static. It has moved in a whole lot of different directions that people never would have predicted. The moral of the story with respect to 12b-1 when 12b-1 was adopted by the SEC in 1980; it was a very good rule in the sense that it was well thought out. If there's any criticism of the Commission over time it is that the rule hasn't been adapted since that time to keep up with what the industry has done. I applaud the initiative to go back and look at 12b-1 because it needed to be looked at for a long time.

The other thing that I applaud the Commission for recently in this area is there's always a focus because the Commission at its heart is basically about enforcement, disclosure and regulation. Whenever we look at the fund business, the history over time is that the Commission thinks there needs to be more disclosure, and maybe there has been a need to have more disclosure. What I'm pleased with with these initiatives is not whether we need more disclosure or not, but where is the best disclosure to be made? The notion of using point of sale disclosure, for example, that has always struck me as the best place to present to a customer or client where the conflicts of interests are and what the problems that person should be thinking about. At point of sale, what are the incentives? That's presented, I always thought, at the point of sale better than in the prospectus, and that's what the Commission rule is all about.

PROFESSOR BULLARD:

Can you describe point of sale versus what happens now, which is that the investor receives a confirmation statement after the sale but doesn't necessarily receive any disclosure

document before the sale.

MR. BARBASH:

At this point in time what happens is if I go out and I buy mutual fund shares through a broker-dealer, I will get a confirmation that will give me information about my purchase, but I will not have gotten anything up front that tells me, if my broker had an arrangement and how my broker was compensated. I don't know as a consumer, client or customer what the conflicts were. And the notion of a point of sale document would be that I would get that document ahead of the game and get some kind of information ahead of the game. I will then get a confirmation after my transaction where probably if I'm a typical investor, I may look much harder at the confirmation which will have everything spelled out as to how the transaction occurred and what the costs were.

I've thought it's a better way to get the message across. Disclosure at its essence is about getting messages to people. For so long, it was viewed that the only document in the mutual fund area that could be used was the prospectus. And the prospectus can be used effectively in a lot of different ways but doesn't work as well as a particularly great document I would contend in all areas across the board.

PROFESSOR BULLARD:

Before we get to Professor Sirri, Mr. Roye or Commissioner Goldschmid, I don't recall whether one of you mentioned the SEC's announced plans regarding Rule 12b-1. Is that on the table? Do you want to add anything to that?

MR. ROYE:

It is on the table, and it's something that the Commission is going to consider probably next month. Commissioner Goldschmid hasn't had the opportunity to see what the staff's recommendations are going to look like, but all I can tell you is that we're focusing at least initially on the issue of directed brokerage and the role that it plays with regard to 12b-1.

COMMISSIONER GOLDSCHMID:

I think that Chairman Donaldson has gently hinted—though it wasn't very gentle—that directed brokerage is likely to go. Let me make a point by picking up on Barry's point in terms of in this particular area preeminently, getting

information out that consumers want is so critically important. At one of the open hearings at the SEC I admitted as a law professor that lawyers don't always write perfectly and get information out that everyone will understand and pieces they think they need. So, we're working with Barbara Roper and working with focus groups and working with others in the industry to make sure we're giving things they understand and want and need. This is almost a new experience for the SEC, but it's really something very useful to do.

PROFESSOR SIRRI:

It seems to me that in these brokerage and distribution payments that really two things have come together at once. They're both factors that have evolved in the competitive landscape in the last fifteen to twenty years in this business. The first is just complexity; something that Don Phillips referred to. As individuals you have a lot more responsibility for your own financial well-being today than you did a long time ago. You've seen the shift to define benefits and define contribution plans for your retirement. There are a lot more products offerings out there today. It's not at all clear to me that people's financial acumen has kept pace with the mix of product offerings.

So what does that do for you? That means there's a greater demand for advice perhaps than there was in the past, and you saw that. After the March 2000 bubble burst, all of a sudden full-service brokers saw an inflow of people looking for advice. The thing that you could do before where you thought you were a management genius on your own. Well, you weren't such a genius afterwards when the whole market went down. So the point here being that the demand for advice, I think, has risen because of how the landscape has gone, I think is something Paul Haaga was referring to that's important to the octogenarians. What do you conclude from that? Well, I think the thing that's important here is that the price for that advice be very, very clear. So that's point one of what's been going on.

Point two, what's been going on is, in fact, I think the competitive landscape has shifted and the profitability has actually moved from the advisor to, in part, the broker. That

is in the chain of value for how funds find their way from the producer to the consumer, the sweet spot in that chain is with the person who controls the distribution channel. That is the broker. The broker is going to extract the rents in this game because of exactly what Barbara Roper said. These for the most part are sold products, and that means, you know, you can change the form today, but the broker's have the point that controls the rents. The broker is going to get paid; they're going to get paid a lot. We can have a discussion about how you choose to pay the broker and that's fine, and it should certainly be clear, but we won't change the equation because that's set by competition. It's the broker who's earning the rents today because the mutual fund product mix, and I don't mean to use this term pejoratively, has a commodity-like aspect. It's very, very hard for funds to distinguish themselves. They don't tend to have consistent performance records. What that means is it's going to be the brokers who earn the high rents in this business, and it's just a question of making it transparent and clear to the final consumer.

PROFESSOR BULLARD:

Why don't we finish with Mr. Haaga, Ms. Roper, and then move on to our final topic before we have some closing remarks.

MR. HAAGA:

I want to follow up on something that Commissioner Goldschmid said about the importance of communicating effectively to shareholders and that lawyers don't always do it well. An anecdote, 1994 was the first calendar year in ages in which bond funds lost money, and it surprised a lot of people; nearly all kinds of bond funds lost money. This is a true story: there was a meeting of shareholders at which an upset bond fund shareholder stood up and said, "I knew that the value of my shares would fluctuate, but I didn't think they'd go down."

MS. ROPER:

I just wanted to say perhaps I'm excessively cynical, but I think it's important to note that the complexity we have in the way we pay for distribution is not a chance occurrence. We got to where we are because investors didn't like paying front loads, and now maybe they should understand that they

should be willing to pay for advice if what they are really getting is advice. But front loads have virtually disappeared because it's easier to sell those products with a 12b-1 fee which people don't understand as well. And it's even easier to sell them when you can put the distribution costs into the portfolio transaction costs, which is what we mean by directed brokerage, because then you don't see them at all. I think distribution costs have intentionally gone into hidden channels or less well understood channels because it makes it easier for the broker to tell the investor that they're getting a good deal; you're getting a no-load fund. Because the choice between a load and a no-load seems so obvious, I don't think this is just a chance evolution. I think it's an intentional shift toward complexity and making things difficult to understand because that makes it easier to sell.

PROFESSOR BULLARD:

We've talked about setting fees and disclosing those to shareholders. We've talked about distribution arrangements and how to disclose those to shareholders. Now I'd like to focus on disclosure to shareholders as such. We have certain vehicles, the prospectus, the shareholder report, financial magazines, other sources that people use.

It is both the simplest question and the most complex question as to how you take all this very complicated information and narrow it down to where the people can use it and think about it and digest it. Why don't we start with Mr. Bogle. Would you like to lead us off again on that issue?

MR. BOGLE:

I find myself a little bit amused by it—the kind of the nature of the conversations we're having here—because we've taken a nice simple business, it's all about simplicity and parsimony, and made it into a business of witchcraft. Something like in 300 B.C. a man named Archilochus left a fragment of his writing that said, "The fox knows many things and the hedgehog knows one great thing." And we have too many financial foxes here that have confused what should be a simple business.

Do you want to own equities and the market return or do you not want to own equities and the market return? And if

you do just own the market, stop fooling around with trying to pick the best managers, stop paying all those high costs and just get all the complexity and the confusion out of the business and all the salesmanship. There's nothing inherently good or bad about complexity versus simplicity except complexity is dreadfully expensive and simplicity is marvelously cheap.

PROFESSOR SIRRI:

I want to respond to that. I'm a customer of yours, of your old employer, so I've got your funds. But I think you have to separate two things here. One is the selection of the fund active versus passive, high cost, low cost, to which you speak. But there's a lot more to advice and there's a lot more to planning than that. Take the simple problem that, let's say, I was thirty years old, and I was saving to buy a house or put my kids in college. Knowing how much equity I should hold, that is not an easy question. It is a very, very difficult question. It's one that would fill ten pages of math. Someone does need to provide you help on that. And, you know, a Vanguard product doesn't help me any more than a Fidelity product or a very actively-managed product for that question. So, I think you've got to keep those two things separate.

PROFESSOR BULLARD:

Mr. Roye, we know we have proposals on fees and proposals on distribution. I imagine you've something you can pull out of the hat on disclosures to consumers as well. The shareholder report or—

MR. ROYE:

Right. Let me just start by saying that, and Commissioner Goldschmid alluded to this, this is the ultimate challenge for the Commission, and Barry alluded to it as well: trying to come up with disclosures that investors can make use of and are easy to understand. I think when you see the point of sale confirmation release that comes out, you see the Commission reaching out. We're going to put it on our website; we're going to be asking investors to weigh in and say, "Is this the way to present this information? Is this the way you want this information? Is there a different way we could characterize or present this information in a way it's going to be useful for

you?" So fundamentally, we have to do a better job of laying information out for investors. And what you see the Commission doing, and I hope we sort of continue this approach, is a layered approach to disclosure. You have the prospectus; you have the statement of additional information; trying to make a cut as to what investors—when they get the prospectus, is the most important information and then the statement of additional information having a lot more.

You have guys like Don Phillips at Morningstar and financial planners who are cosponsoring this. They want everything. They want it all broken down. They want as much information as possible so they can advise their clients and make decisions. And then there's reports. What does the average investor want and need? We are probably going to—when we get through dealing with the scandals and the other issues—step back and try to focus on how we can improve that disclosure. We do have the shareholder report project that the Commission is going to consider next month. It's going to force portfolio disclosures out there more frequently. They will be able to look at the portfolios now four times a year on a sixty-day lag, putting investors in a position to make better asset allocation decisions, knowing what's in the various fund portfolios we think will be helpful. Again, focusing on the fee issue and trying to force better disclosures in dollars and cents, trying to force funds to present tables and graphs categorizing the nature of the portfolio and the structure of portfolio and help investors understand. To try to get fund managers to do a better job explaining why the fund performed the way it did or didn't in their discussions, and requiring the discussion to be in a shareholder report. And then trying to do some streamlining of the documents so hopefully investors will get it and not throw it in the trash. We're going to recommend that the Commission adopt a summary portfolio schedule requiring funds to show you the top fifty holdings, any position over one percent. For the investor who wants the portfolio—a financial planner—you want everything, you will have access to it. How can we encapsulize this information the way that investors can use it and will read it and make use of it?

PROFESSOR BULLARD:

Of course, Mr. Roye comes from the perspective of: what should the government require that the regulated entities disclose? Mr. Phillips comes from a different point of view as one of the leading voices at Morningstar. He's in the business of deciding what the market wants to buy in terms of information. What's your perspective on this issue?

MR. PHILLIPS:

Well, I would encourage the SEC to focus on one very simple thing: "What does an investor have a right to know?" When you start making this more complicated by saying what they are capable of knowing, what do they want to know, then there is a huge range, a huge spectrum out there of that. But focus on what as an owner—getting back to Jack's point of owner's capitalism—what do you have a right to know. What sort of things would help you make an informed decision? And then correctly, as Paul alluded to, you'll recognize that there is a huge body of people out there helping with this: the growth of the financial planning association, the no-load and fee-based advisors, the tremendous explosion in the personal financial press that's out there and the growing number of academics that are looking at mutual funds as a serious area of research in addition to the groups like Morningstar that would use this data. You'll recognize that all of that is part of the market process. So just focus when you're saying what information should be out there, just say, "Is it information that an investor as an owner has a right to know?" If it's not, don't put it in it. If it is, make sure it's out there.

MR. ROYE:

Yes, but Don, I think I agree with that. We should force information out there that investors have a right to know, but we also have to worry about overwhelming the ordinary retail investors with everything they have a right to know. I want to make sure the information is out there and it is accessible, and if you want it all and you can understand it all, it's there for you. But what does the ordinary investor want and need to know? We want investors to tell us that.

MR. PHILLIPS:

And you're right about the sharing of the information, and I agree with you. That's a worthy thing, and it's something

that you need to work through. But keep in mind that when I started in the fund industry, the fund industry did not have to disclose who the portfolio manager was, and the industry fought tooth and nail against that disclosure. We went on the old FNN network debating representatives of the ICI who would say things like, "Well, what if we have that information out of there and then the fund manager changed, but it was still a good fund and the investor panicked and sold the fund? Wouldn't that be terrible?"—that sort of paternalistic attitude. We just turned around and countered and said, "Wait a minute. Would any fund manager buy stock in General Motors if GM wouldn't tell them who the CEO was?"

It's got to get back to that right to know. And I think there's a wonderful template for right-to-know information in corporate America. And I think we should look to that in thinking about what investors have a right to know. Fund managers would not give up the information that they have on corporate America, and yet they turn around and give less information to people making mutual fund decisions. You have got to make decisions as to what goes into the different documents. I just want to make sure that at the base of that for those informed parties, the academic community, the financial planning community, the financial press, that the basic information they have a right to know is available at some level so that we can enhance the dialog and really get to the biggest failing of the mutual fund industry.

All of this stuff that's being talked about is significant, but the real problem is the horrible misuse of funds. People in the aggregate are buying good funds, but there are some rotten portfolios because they're going out and chasing last year's winner. They're not making informed decisions, and you need more core information out there to elevate the debate and get beyond good fund/bad fund towards a better usage of funds.

MS. ROPER:

It is possible, given the information we now have, to make excellent choices about how to invest. As you look at changing the disclosure rules—and there are people out there who are doing it—I don't want to end up with a system where we do a better job of disclosure for the people for whom it already

works. And I think it has to start from the people for whom it doesn't work and that we begin by looking at the people who are making bad decisions and figure out why they're making bad decisions and what would cause them to make better decisions. That should drive the decisions about how we change disclosure—not so that people who can already figure how to use web-based materials and Morningstar and what's in the prospectus can do an even better job—but so that the people who are now doing a bad job and who's retirement savings or college savings or home savings is suffering as a result, so that those people can also join the party and take advantage of what are some great mutual funds out there.

MR. ROGERS:

One of the concerns I have because I agree with full disclosure: we have always believed in quarterly reports and trying to get everything out in the open, but I do worry that a lot of the discussion today has been around large fund companies. There's a sense that everybody's thinking more about Vanguard and Fidelity and the giants. I still hope there's going to be a role in the future for entrepreneurial small fund companies that can bring creativity and value to the marketplace. You worry sometimes when you're spending so much of your time during the day with your lawyers and going through the quarterly report and making sure everything's perfect and then the internal counsel and external counsel.

The amount of expense in small fund complexes, I think, endangers the ability for some fund complexes to start. It may become a barrier to entry for the next generation of entrepreneurs in this industry. And then the other part of that is that often smaller fund companies, the portfolio manager like myself, is also a major owner in the investment management company, and some of the things Don and I were talking about were that I think it is a good idea for disclosure to have how the portfolio manager is getting compensated and how many shares that fund manager has in their funds is important. But also as interesting as it is, I think it is probably equally or more important to know how many shares or how much of the portfolio manager owns in the actual fund management company because you have a choice. Do you want to

own a lot of the business that you've built, or do you want to own shares in the fund that you're managing? It's kind of an interesting quandary there, but at least the one thing with a firm like ours, our interests are aligned. Whether I'm a big shareholder in Ariel Capital or a big shareholder in Ariel Fund, it's important for them both to be successful and grow.

PROFESSOR BULLARD:

We're running a little short on time, and, of course, this conversation will go on, not just for months, but for years on end. But I'd like to close looking forward a little bit and give everybody a chance to make a statement. I'll limit it to ninety seconds and answer the question for us. Clearly mutual funds are American's investment vehicle of choice. And even through the scandal, money has been pouring into these funds. So the question I have for you is: "What do you see having to change over the next ten or twenty years for funds to continue in that position?" Particularly for Commissioner Goldschmid and Mr. Roye maybe the question is: "What broad regulatory fronts have to be conquered for that to continue to be the case?" Why don't we lead with Mr. Barbash and go around the table to conclude the summit.

MR. BARBASH:

Well, first and foremost, I think there's a long history that mutual funds have worked. If they didn't work, I don't think investors would continue to put money in. It has to be fundamentally a sound investment vehicle, and it has to work because American consumers, if it didn't, would go to something else. And we start from that premise. In terms of where the industry needs to go, I don't know that we can really predict where the industry needs to go. I think I can talk about what are the major concerns we face right now. I think John Rogers makes some very good points with respect to the mutual fund industry. I get concerned with the amount of regulation and what that's going to mean for the entrepreneurs. I get concerned that entrepreneurs are going to look to another business, not going to want to get involved with the lawyers. It's been a greater degree of regulation across the board and has been great for fund lawyers, but I'm not so sure it's been great for the entrepreneurs who matter a lot more as it goes with

the industry.

I get concerned about greater consolidation—that the tendency will be for the entrepreneurs not to come in and for companies to get bigger and bigger market shares, which is great. There are some really excellent companies out there, and I'm not sure as a matter of policy that's so terrific. So, I think, I'm not suggesting in any way, shape or form, that it's not important to regulate. I'm not in any way, shape or form suggesting that there haven't been problems. I just think that there needs to be some balanced approach to regulation and a reassessment over time whether all of it is necessary or whether it should be tweaked.

MR. BOGLE:

Back in 1949, when I read about this industry for the first time in *Fortune Magazine*, they used terms like trust, trusteeship, trustees. And what have we heard today? We've heard things like classic marketing business. We've changed from a business of management to a business of marketing. We hear product, point of sale, shelf space, producers, consumers, high rents. Those things have a lot to do with merchandising and marketing and not anything to do with management. Back in those days, this industry had middle-of-the-road funds, which were much more important then they are today. Costs have doubled since then.

Portfolio turnover has gone up eight times, and instead of small professional firms like John's being in the driver's seat back then, we're owned by great big financial conglomerates whose interest was a return on their capital and not a return on your capital. So, my solution is to send public policy in the direction of back to the future. Let's see if we can recapture that great industry of 1949.

COMMISSIONER GOLDSCHMID:

That's a good idea in general, but let me start with Barry's point. The regulations we're proposing are aimed not at increasing cost. We've done this for public corporations and others. It's a marginal increase and we're focused on small funds and small businesses to make sure we're not. No one wants entry barriers here, although by numbers this is a very competitive business. We don't want that part of it to change.

Common ground is that this has been a wonderful industry. The growth to that seven trillion dollar figure indicates success.

On the other hand, it clearly needs change. And this period and what the SEC is doing and what may be done on Capitol Hill, will certainly lead to the largest period of change since 1940. For me that's all to the good. An enormous advantage of SEC regulation is the ability to keep track of it, to change things by rules, to build in flexibility, to make sure we're not hurting change or entrepreneurial activity. For me that's all going to work. I mean, I'm very optimistic. But I should give Paul Roye a compliment. He's done a wonderful job in a very short period of picking up and doing what's needed here. This really is a major set of changes, and Paul's led that with extraordinary skill, I think. And Mercer, I would pick up what Paul Haaga said at the beginning: You put together a wonderful program, and we all came because we have such respect for you.

PROFESSOR BULLARD:

I appreciate that. Mr. Haaga?

MR. HAAGA:

Thanks. Right before New Year's I was listed in the *New York Times* as the recipient of one of the 2003 dubious distinction awards along with Dennis Kozlowski and a couple of other notables. It was called "The Pride Goeth Before a Fall Award" and it was for making a speech to the investment company industry back at the annual meetings last May in which I attributed the success of the industry—its growth from six percent of families in 1982 to fifty percent now and seven trillion in assets—to the fact that we've been free of scandal. Of course, that's come back to haunt me. My kids, by the way, loved it, and they thought it was the funniest thing they've ever seen. They have multiples copies of it and they will show you any time you want to see it. People came to me afterwards and said, "Aren't you sorry you said that?" My answer is always no, actually, I wish I'd said it more often because I wasn't boasting. I was reminding us that what got us, what got us to be the investment of choice for the majority of Americans and a super majority of middle-income Ameri-

cans is the fact that we've earned their trust, and we need to get back to that. We have had scandals. It hasn't involved everybody, but as soon as it involved one person from one fund group, I quit counting because that was enough to make it a problem for us. We need to earn back your trust, and we will earn back that trust. And we'll have a lot of help from the people around this table, the regulators and the legislators, but we're ultimately going to have to do it ourselves.

MR. PHILLIPS:

We haven't really delved into the scandals here, but as Paul mentions, it really gets to the heart of the whole issue and that is trust. The fund industry has grown because people trust, and I think the real challenge is how does the industry respond? Does it respond by saying what's the minimum we have to do to make this mess go away so we can get back to the business we liked so much three years ago? Or do they respond by saying what's the most we can do to help put the industry on the proper footing to protect that trust for the next fifty years? I think the result will be somewhere within that spectrum. I'm optimistic because of some changed behavior by some senior fund officials that perhaps the answer will lean more toward the latter. The very fact that we're here today talking about these, and as Paul said talking at each other, talking with each other, is because of frankly some of the terrific work that the SEC has done. My hat's off also to Paul Roye and the team there. Perhaps the answer will be more towards the latter, which is where it needs to be because America needs mutual funds. Americans need this investment vehicle, and they need to know when they put their money into mutual funds that they can trust them.

MS. RICH:

I couldn't agree with that more. America needs mutual funds. It's one of the most landmark developments in the financial markets in the last sixty years. It's funny that the elephant in the room really hasn't been mentioned which is the scandal, Eliot Spitzer, and everything that has been in the headlines every single day. Yesterday it was a hundred billion dollars and MFS. A week ago was how the fund's scandal runs wide and deep. I think what needs to happen right now is a

change in attitude among fund directors in the board rooms, among regulators, among members of Congress, among the industry, participants themselves, among investors, and that's happening.

As a result of these scandals, which is a good thing for the industry, it's a good thing for the regulators, and it's a good thing for Congress. Frankly, when a scandal becomes part of everyday lexicon and when the *New Yorker Magazine* is talking about investment companies, then you know something's going to happen. I think what's going to happen is you see the excellent work at the SEC, they've done an amazing amount of work adopting rules that were initially in the legislation that Chairman Baker introduced back in June, which has evolved to include more provisions that the Commission is responding to and more needs to be done.

I think that in order to make those changes happen, you have to promote investor confidence and let them understand that there is a change in attitude by the board of directors that is charged to oversee their interest. Also, legislation really needs to pass so that we can say that something's been done concretely to make that change.

MR. ROGERS:

For the industry to continue to grow and thrive over the next ten years or more, I think there needs to be a little more of a focus and a concern around diversity issues. Along with Charles Schwab, we've done surveys the last six years or so on African American investment patterns and have found that people of color, African Americans and Hispanics, are much less likely to get involved in the stock market and are much less comfortable investing in their 401K plans. When they do get involved in a defined contribution plan, they often are very conservative in their investment choices.

And nowadays as the old-fashioned pension funds are being replaced more and more with defined contribution plans, I think it's going to be a critical issue facing our country in the future. So I think that investor education is very, very important; we've got to try to get into our schools throughout this country and we've got to give more seminars. I know that the SEC and the ICI are big believers in that. I think we just

have to keep fighting hard because investor education is critical. Also, there should be more diversity in our industry. More people of color on fund boards and more people of color in management positions because that will also help to spread the word and encourage more people to get involved and invest and learn the magic of compound interest.

MS. ROPER:

I was in the car the other day with my son who is nine and a couple of his friends who are playing the stock market game at school in fourth grade, and they were asking me what stocks they should buy as part of their stock market game, having a vague notion that I do something. And I found myself explaining to a carload of nine-year olds that they really didn't want to invest in individual stocks. They need to diversify their holdings. My point is, one, I think you need to get stock market game out of the school and get the mutual fund game in.

I believe in mutual funds. My concern is I don't think the industry really does have to change to continue to be very successful. For people who have only a modest amount of money to invest, the only way you can get broad diversification is through mutual funds. If you're rich you can have separately managed accounts or you have other options, but for middle-income Americans who are going to be funding their retirement this way there isn't another game in town. That it is why it is so important that in this environment, the SEC has stepped up to the mark and is looking to take action. Congressman Baker got there ahead of the scandals and realized something needed to be done. Policy makers are stepping in because I don't think investor behavior will force this change. I think it's going to have to come from the top down.

MR. ROYE:

I think I would echo really what's been said. A lot of this comes down to trust. If the industry's going to be successful ten years from now, investors need to feel like they can have confidence in the management companies. They need to have confidence that independent directors are there to protect their interests. They need to have confidence that their regulators can protect them.

I think we're going through that self-examination process at the Commission. How can we get smarter? How can we do a better job? I want to address Barry's point from a regulatory overkill perspective. Commissioner Goldschmid alluded to this. We're not looking at these things and not considering the cost and the impact. I think on some of these issues the industry's left us no choice. And when I say the industry, it's not just the mutual fund industry. I think one of the problems that we have here—and I've seen it in talking to fund directors, and we've had issues with break points, and things like that. A lot of this goes to the brokers and who's selling the products. I've had mutual fund directors say to me, "Well, that's not our problem." Well, guess what, look at the late trading, the market timing, the break point issues. They all come back to who's selling the funds and the integrity of those folks. So it's not just a mutual fund issue. It's a broker and intermediary issue, and I think we have to focus on that as well.

PROFESSOR SIRRI:

Well, it's always fun to be a professor because you can think sort of pie in the sky here. I look at mutual funds as sort of an interesting vehicle because, I mean, they've been very, very successful. There must be something about them that works, but to me they are just a means to an end. There is, in fact, nothing special to me about a mutual fund. They're wonderful vehicles to pool capital, to save and to get exposure to the market. But I think to get at Mercer's question which is, where are mutual funds going to sit ten plus years from now, I think it depends how innovative they are and how innovative this business is. You all face basic risks as investors. When you save money, you basically have three things you need to get done: you've got to buy a home, you've got to put your kids in college and you need to retire. That accounts for most people's needs to save. That's what they do. Now it's no simple calculus to figure how to go from that to a fund of stocks and a fund of bonds and all the various options that are offered to you. To my way of looking at the world, it's actually the fund industry and the financial services industry more broadly that has a long way to go to help you with the risks that you face and to help you find solutions to these broad life

cycle problems that you face in savings and going ahead with your life, so, as Paul Haaga put it, you don't run out of money. I think mutual funds will be part of the solutions. But to echo Barry's point, I think it's important that the costs do not creep up, or mutual funds will be hobbled, and someone else will come to replace them in solving those very, very basic problems that you face.

MR. TYLE:

It's always scary to go last. I think the biggest determinant as to where the industry—where mutual funds and mutual fund investors will be ten years from now—is how the issues that are currently before the SEC and Congress are resolved in the next year or so. If there is not a forceful enough reaction to the scandals that we have not spent much time on, I think investors are going to lose confidence. I think problems and flaws in the system were clearly resolved. I think the SEC proposals, while I certainly disagree with aspects of them, by and large are a forceful and appropriate response there. I think we need to do two additional things. I think there need to be more resources to oversee the industry, and I think it is very clear there needs to be oversight of those entities that were doing the abusive trading in mutual fund and hedge funds.

On the other side, if there is an over reaction—and Barry Barbash made this point earlier—I think you will drive out entrepreneurs. If you go to something like—and I heard hints of it here today—some sort of quasi-utility rate making function, not done by the SEC, but done by mutual fund boards, you will have the same effect. You will have a less diverse, less innovative, more concentrated, and I suspect, ultimately, more costly product.

And finally, I think it's very tempting when we're looking at these issues to be nostalgic about past times, but I think it must be borne in mind that over the last twenty to thirty years, mutual funds have democratized the markets. There are millions of people now in mutual funds that before were in fixed rate bank accounts earning three percent, far under performing the S&P 500. And some of those marketing costs have actually gotten people into the markets and made it

easier for them to save for homes, retirements, etc.

PROFESSOR BULLARD:

Thank you, Mr. Tyle. Thank you to the panelists. That was, as I expected, I think the best discussion of mutual fund issues I've ever seen, and I've been to a lot of conferences. I feel the same way that Jack and Paul do when they see that Vanguard ad in the *Times*. I'm really sorry to see it come to an end. I do want to correct one misimpression though, the idea that somehow I was the reason that we were here. The reason we are here is that this very illustrious group was willing to take the time out of their very busy schedules, to go a long way out of their way in order to get together and talk about these issues. I really would like to express my appreciation to the audience for attending, to our webcast audience wherever you may be and especially to our panelists for bringing to us a truly unique event in the history of the University of Mississippi. Thanks very much.

COMMENTS ON THE MISSISSIPPI TASK FORCE ON GENDER FAIRNESS AND ITS FINDINGS

John W. Winkle III[*]

That people should enjoy equal access to, and equal treatment from, their legal system is a basic precept of good government. At the heart of this precept is public confidence in the integrity and legitimacy of courts as fair and responsive institutions. Popular trust turns in large measure on whether people believe that the legal process and its core professionals treat them in a just and evenhanded manner. These legal professionals are themselves influential agents in this context. Judges, attorneys and court personnel help to shape public experiences with, and impressions of, our criminal and civil justice systems. Their behavior and perceptions may reinforce or dispel popular suspicions of bias. How they see or fail to see evidence of unfairness and how they respond may spill over to users of courts and non-users alike. These derivative views, in turn, may influence the level of public confidence in the courts as impartial and authoritative decision makers.

With so much at stake, the study of bias in American courtrooms is both important and timely.[1] Because our legal culture values fairness and equality, the presence of any prejudice may impel us as citizens to question the legitimacy and outcomes of legal proceedings. While a recent national opinion

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[*] Professor of Political Science, University of Mississippi. B.A., Mercer University (1969); M.A., Ph.D., Duke University (1972, 1974).

[1] *See generally, e.g.*, John W. Winkle III & Justin Wedeking, *Perceptions and Experiences of Gender Fairness in Mississippi Courts*, 87 JUDICATURE 126 (2003); Judith Resnik, *Asking About Gender in Courts*, 21 SIGNS 952 (1996); Lynn Hecht Schafran, *Gender Equality in the Courts: Still on the Judicial Agenda*, 77 JUDICATURE 110 (1993); WOMEN, THE COURTS, AND EQUALITY (Laura L. Crites & Winifred L. Hepperle eds., 1987); Lynn Hecht Schafran, *Educating the Judiciary About Gender Bias: The New Judicial Education Program to Promote Equality in the Courts and the New Jersey Supreme Court Task Force on Women in the Courts,* 9 WOMEN'S RIGHTS L. REP. 109 (1986).

survey by the American Bar Association found that some eighty percent of Americans regard ours as the premier justice system in the world, it also revealed "serious disparities in perceptions of the justice system with regard to racial and gender fairness."[2] For decades, research and scholarship focused on racial injustices in the legal process; now it includes gender as well.

Gender bias is multidimensional. By definition it suggests that human biological differences may be transmuted into harmful societal distinctions. Such distinctions may encompass perceptions of work assignments, myths about social and economic realities and stereotypes that society has ascribed to men and women. Unfairness in the legal system may manifest itself in multiple forms. Gender bias may be intentional or unintentional, overt or subtle, official or unofficial. It may appear in the language of statutes or in the judicial interpretation of those statutes. It may be revealed in inequitable salary and benefits packages for those who work in the court system. And it may also surface as insensitive attitudes and disrespectful treatment in the interactions between judges, attorneys and court personnel. All participants, lay and professional alike, should expect to be treated with similar dignity. Over time, however, evidence abounds that this expectation for American justice has gone unmet.

Created by order of the Mississippi Supreme Court in 1998,[3] the Mississippi Task Force on Gender Fairness in the Courts (Task Force) joined more than forty other jurisdictions nationwide[4] in an exploration of conditions, attitudes and

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[2] Philip S. Anderson, Opening Remarks, *American Bar Association Symposium II: Public Understanding and Perceptions of the American Justice System*, 62 ALBANY L. REV. 1304, 1305 (1999).

[3] The Administrative Office of Courts holds on file copies of the two relevant Supreme Court Orders: the authorizing order, No. 97-M-01581, issued on August 26, 1998 and the extension order, No. 89-R-99028, issued on January 18, 2001.

[4] Special task forces, appointed in states and federal circuits, make up the National Gender Task Force Movement. *See* Gender Fairness Strategies Project, *Implementation Resources Directory* (Jan. 1999), *available at* http://www.legalmomentum.org/njep/PDFdocs/ird.PDF (last visited Aug. 10, 2004); Lynn Hecht Schafran, *Documenting Gender Bias in the Courts: The Task Force Approach*, 60 JUDICATURE 280 (1987).

behaviors in the legal process. Its prescribed charge was to determine whether and to what degree gender bias existed in the state court system and to offer recommendations designed to reduce and ultimately eliminate any unfairness. Fifty Mississippians, drawn from the ranks of retired and former judges, attorneys, court personnel, university faculty, business leaders and others, volunteered to serve on the Task Force because of their interest in the improvement of the state court system. Led by Honorary Chair Evelyn Gandy and Co-Chairs Deanne Mosley and Amy Whitten, the Task Force worked diligently to meet its mandate. It convened in plenary session almost quarterly during its four-year life span, and its committees (described *infra* in the *Final Report*) met regularly as well to address assigned duties.

The Task Force approached its charge without preconceived notions about the nature and scope of gender bias in the Mississippi court system. Its investigation proceeded in a professional, systematic and conscientious fashion. The Task Force drew upon the experiences of other task forces, appointed by state supreme courts and federal circuit councils, to help it understand and frame issues of gender fairness and unfairness. Members of the Task Force and retained consultants studied reports from other jurisdictions, prepared questionnaires specially tailored both to legal groups and the public, analyzed data results from written and telephone surveys and developed a set of recommendations. The Task Force prepared and submitted two interim reports to the Supreme Court and the Legislature to keep those two bodies apprised of its work.[5]

As instructed by the Mississippi Supreme Court, the Task Force sought the views of those within the legal community and those outside. Other task forces reported that the perceptions and experiences of legal professionals were especially useful in identifying sources of bias. To that end, the Task Force modeled its sets of questionnaires for judges, attorneys

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[5] The first report treated the time frame from the inception of the Task Force in 1998 through May 2000. The second extended coverage through October 2001. Copies of these interim reports are available on file at the Administrative Office of Courts.

and court personnel after successful ones elsewhere. Its Executive Committee identified the four broad areas of substantive concern for treatment in these surveys: the legal environment, access to justice, domestic and family law and criminal law. To tap the lay perspective, the Task Force authorized a telephone survey for the general public,[6] held public hearings across the state, and solicited written comments from citizens. Importantly, the findings, and ultimately the recommendations of the Task Force, on the issue of gender fairness were well-grounded in the contemporary experiences of Mississippians. Not only did the legal professionals have daily working contact with the courts, but significantly more than half of those in the public survey reported actual involvement—as jurors, witnesses or litigants—in the legal process.

The Mississippi Task Force on Gender Fairness submitted its *Final Report* in November, 2002 to the Mississippi Supreme Court and the Mississippi Legislature. On the whole, its results are positive, but the presence of harmful gender bias is undisputed. Three broad findings, consistent with those from studies on gender bias in other states, emerged from the Task Force study. First, substantial numbers of those surveyed believed that patterns of gender unfairness existed in the Mississippi court system but perceived them to be low, limited and nonsystemic. Second, a majority agreed that a greater measure of unfairness toward women than men still existed. Third, and importantly, both perceptions of and experiences with issues of fairness or unfairness differed significantly between men and women, the "two different worlds" phenomenon identified by the Ninth Circuit Task Force.[7] Task force reports nationwide confirm, moreover, that perceptions divide along the lines of gender and, to a lesser extent, position.[8] Like counterparts elsewhere,[9] women in Mississippi

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[6] The Task Force contracted with the Social Science Research Lab at the University of Mississippi to prepare and conduct the surveys and analyze the results. The processes of data collection are described *infra* in the *Final Report*.

[7] D.W. Nelson, *The Effects of Gender in the Federal Courts: The Final Report of the Ninth Circuit Gender Bias Task Force*, 67 S. CAL. L. REV. 745, 951 (1994).

[8] Vickie C. Jackson, *What Judges Can Learn from Gender Bias Task Force Studies*, 81 JUDICATURE 15 (1997); Lynn Hecht Schafran, *The Obligation to Inter-*

illustrated greater awareness of the core issues and were much more likely than men to observe and report incidents of biased behavior.

The study of gender fairness in the Mississippi legal system has been an important and necessary undertaking. Efforts to insure that litigants and legal professionals alike are treated with impartiality and respect serves well the interests of the administration of justice. The Mississippi Task Force on Gender Fairness in the Courts has made an important contribution to our knowledge and understanding of the subtle gender dynamics at play in our legal system. Policymakers would be wise to heed their recommendations.

The text of the *Final Report* that follows remains unaltered except for the removal of the Executive Summary which duplicated findings and recommendations. Additionally, because of space limitations, none of the appendices, including the Supreme Court Orders, the by-laws of the Task Force, demographics on the Mississippi bar and bench and the survey instruments, are included. These documents are on file with the Administrative Office of Courts in Jackson. Copies of the *Final Report* are also available in the respective law libraries at the University of Mississippi School of Law and the Mississippi College School of Law.

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vene: New Direction from the American Bar Association Code of Judicial Conduct, 4 GEO. J. LEGAL ETHICS 53 (1990).

[9] This gender divide appears rather widespread. The recent report of the First Circuit Gender, Race and Ethnic Bias Task Force, for example, stated:

> [T]he survey responses reveal a difference of perception with respect to both individual experiences and overall impressions of bias between women and minority respondents on the one hand and men and non-minority respondents on the other. Women tended to report experiences of gender bias with greater frequency than men, and more women than men expressed a belief that gender bias—albeit limited—does exist in the courts and offices of the First Circuit.

Report of the First Circuit Gender, Race and Ethnic Bias Task Forces, 9 B.U. PUB. INT. L.J. 173, 182 (2000).

FINAL REPORT OF THE SUPREME COURT OF MISSISSIPPI TASK FORCE ON GENDER FAIRNESS August 26, 1998—October 31, 2002*

SECTION I: INTRODUCTION

The mission of the American judicial system is to adjudicate cases in a just manner. Citizens find courts more accessible and place more trust in them to resolve disputes justly if they believe that the legal process and its actors value and promote fairness. A fundamental goal of any court system should be to identify and eliminate the damaging effects of systemic and non-systemic unfairness. The potential harm is too great to leave these concerns unattended. If court systems do not treat legal professionals and other participants in an impartial way, they undermine their own fundamental role as chief dispensers of justice. As Chief Justice Charles Evans Hughes once said, the unbiased administration of justice depends upon "civilizing influences which create standards and traditions beyond and above the law."[1] Public confidence in

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* Published as prepared by Professor John W. Winkle with sytlistic changes made by co-chairs Deanne M. Mosley and Amy D. Whitten. The Task Force Membership included Former Lieutenant Governor Evelyn Gandy, Honorary Chair, Deanne M. Mosley, Co-Chair, Amy D. Whitten, Co-Chair, Justice Reuben V. Anderson, Sharion Richardson Aycock, Debbie Bell, Patricia W. Bennett, Mary Carol Bowers, Mary Lee Walker Brown, Vivian D. Brown-Toussaint, Mark Allan Chinn, Judge Shannon Clark, Dr. Frances Coleman, Representative Linda F. Coleman, John G. Corlew, Polly J. Covington, Betty Daugherty, Sally Burchfield Doty, LaVerne Edney, D. Elizabeth Featherston, Judge Robert L. Gibbs, James L. Henley, Jr., Beverly Hogan, Clare S. Hornsby, Charles C. Jacobs, Jr., Elizabeth Jenkins, Walter T. Johnson, Beverly Pettigrew Kraft, Betty J. Long, Lynn Fitch Mitchell, Monique Montgomery, Dr. Jessie Mosely, Dr. Melinda Mullins, Ann Odom, Judge Robert H. Oswald, Gayle Parker, Charliene Roemer, Lisa M. Ross, Jackie W. Rozier, L.F. Sams, Constance Slaughter-Harvey, Lynn Hughes Sorey, Grady F. Tollison, Susan R. Tsimortos, Lieutenant Governor Amy Tuck, Vangela M. Wade, Shannon Warnock, Carol C. West, Dr. Alvin J. Williams and Karen J. Young.

[1] Charles Evans Hughes, Speech to the Annual Meeting of the American Law Institute (1929).

the integrity and legitimacy of courts as authoritative institutions depends in large measure on the reality of evenhandedness.

Today, approximately fifty participants, including states and federal circuits, make up the National Gender Task Force Movement.[2] Of great importance is the fact that the judiciary itself has assumed the responsibility for these inquiries. The final reports issued by these task forces are designed to enhance the fair administration of justice.

Support from the Judiciary

Special commissions on gender fairness have received endorsement not only from supreme courts in individual states, but from major associations of state and federal judges as well. At the state level, the Conference of Chief Justices passed resolutions in support of task forces to study gender bias in courts and urged chief justices to formulate strategies to improve public confidence in courts.[3] Similarly, the Judicial Conference of the United States, the principal administrative

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[2] *See,* Gender Fairness Strategies Project, *Implementation Resources Directory* (National Judicial Education Program, 1998). For the relevant professional literature on this movement, see, among others, Wikler, "On the judicial agenda for the 80s: equal treatment for women and men in the courts," 60 *Judicature* 202 (1980); Schafran, "Educating the Judiciary about Gender Bias: The New Judicial Education Program to Promote Equality in the Courts and the New Jersey Supreme Court Task Force on Women in the Courts," 9 *Women's Rights L. Rep.* 109 (1986); Schafran, *Documenting gender bias in the courts: the task force approach,* 70 *Judicature* 280 (1987); Schafran, "Women in the Courts Today: How Much Has Changed," 6 *Law and Inequality: A Journal of Theory and Practice* (May 1988); Schafran, *Women in the Courts Today: How Much Has Changed,* 6 *Law and Inequality* 27 (1988); Schafran, "Gender equality in the courts: still on the judicial agenda," 77 *Judicature* 110 (1993); Kearney & Sellers, "Sex on the Docket: Reports of State Task Forces on Gender Bias," 56 *Pub. Admin. Rev.* 87 (1996); Judith Resnik, "Asking about Gender in Courts," 21 *Signs: Journal of Women in Culture and Society* 952 (Summer 1996); Kearney & Sellers, "Gender bias in court personnel administration," 81 *Judicature* 8 (1997); Judith Resnik, "Singular and Aggregate Voices: Audiences and Authority in Law and Literature and in Law and Feminism," in Michael Freeman and Andrew D.E. Lewis, *Law and Literature, Current Legal Issues* (1999); "Report of the First Circuit Gender, Race and Ethnic Bias Task Forces," 9 *Boston Pub. Int. L.J.* 173 (2000)

[3] *See, for example,* the Resolution adopted at the twenty-first Midyear Meeting of the Conference of Chief Justices on January 29, 1998.

policymaker for the federal judiciary, encouraged circuit judicial councils to conduct studies with respect to gender bias in their respective circuits.[4] In its recent *Long Range Plan for the Federal Courts*, the Conference recognized that "both intentional bias and the appearance of bias impede the fair administration of justice" and recommended that "federal judges should exert strong leadership to eliminate unfairness and its perception in federal courts."[5]

Cautions

The Task Force reviewed reports issued by task forces nationwide which assisted in structuring its investigation and placing its findings within the national framework. It is necessary to address two universal concerns about the validity of task force findings. These concerns turn on evidentiary matters, and the meaning and application of perception and intent versus reality.

Perception

Task force reports have relied upon social science survey research techniques to ascertain the perceptions and experiences of legal professionals and the general public. In an effort to minimize or even dismiss selected findings, critics sometimes point to a distinction between objective reality and subjective perceptions of that reality. Critics claim that the evidence of gender bias is "all in the heads" of respondents.[6]

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[4] Report of the Proceedings of the Judicial Conference of the United States 28 (March 1993).

[5] *The Long Range Plan for the Federal Courts*, Recommendation 78, at 112.

[6] Chief Judge Patricia Wald, U.S. Court of Appeals (D.C. Cir.) described and reacted to such a suggestion. "During the debate there was much talk of perceptions as opposed to reality: "What was in our heads" as opposed to "what was happening in the real world?" Women perceived they were treated differently; but we told repeatedly the perception was of our own making. It didn't seem to matter that the women answering the questionnaires and in the focus groups reported actual incidents that happened to them or that they had personally observed – it was still only a perception – we were told – that the cause had anything to do with their gender, even when it happened so much more often to women than to men as to be statistically significant." Chief Judge Patricia M. Wald, Remarks to the Aspen Law & Business Institute, Aspen, Colorado, June 12, 1995.

While social psychologists may argue that perceptions constitute reality for observers, invoking that research is unnecessary here. An exceedingly strong experiential basis for the views of Mississippians emerges in these surveys. Respondents, whether judges or lawyers or court personnel, work daily in and are intimately familiar with the Mississippi legal system. Their perceptions ought not be dismissed as imagination. Furthermore, as detailed below, a majority of those who participated in the public telephone survey reported actual experience with the Mississippi court system as jurors, witnesses, or litigants. Task force reports, in general, tend to conclude that women perceive more instances of gender bias than men because they live them.

Intent

The more common reaction to findings contained in task force reports centers on the intent of those who allegedly engage in biased behavior. It often manifests itself in the notion that "I don't do it, because I don't intend to do it." If the remark or the conduct, for example, bears no prejudicial intent, where's the real harm? And if such action or inaction, especially on the part of legal professionals, is unintentional, is a remedy needed? The implication seems to be that unless discriminatory intent is clear, the act by definition is inoffensive. Task force reports from other jurisdictions indicate that while both women and men may hold this viewpoint, men do so with greater frequency. This outcome may be attributable to the decidedly masculine nature of American legal education and courtroom culture over time. As a result, men are less likely to observe these behaviors, or, if they do, are less likely to understand their impact and why they are manifestations of bias. As the Utah Task Force found, for example, the conduct or remark "may be unintended and unrecognized by the perpetrator, but still be perceived by the victim as offensive and harmful."[7] In summary, the absence of prejudicial intent is

[7] Utah Task Force on Gender and Justice, *Report to the Utah Judicial Council* (March 1990) at 10.

less important than the effect of the behavior on its recipient. Its consequence is to undermine personal confidence in legal professionals and, most important, to diminish public faith in the integrity of courts.

SECTION II: THE MISSISSIPPI TASK FORCE

Origins

The effort to investigate the nature and scope of gender unfairness in the Mississippi legal system traces its origins to 1995. Appointed by Chief Justice Armis Hawkins, Court of Appeals Judge Mary Libby Payne represented the state at the National Judicial College's Institute on Gender Fairness in the Courts. Upon her return from that conference, and during the next two years, she and Lieutenant Governor Evelyn Gandy met with an informal group of women chaired by Judge Tammy Harthcock who were interested in improving the legal environment. In December 1997, a group of female judges and attorneys[8] took the initiative and filed a petition before the Supreme Court to establish a gender fairness task force in Mississippi.[9] Some eight months later, the Court granted the petition and created the Supreme Court Task Force on Gender Fairness in the Courts.[10]

Mandate

The Court Order set forth the following twofold mandate for the Task Force: "to consider whether gender bias does exist in the judicial system and Bar of Mississippi, and if such gender bias does exist, to determine the nature and extent of such bias and to propose measures for its reduction and ultimate elimination."

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[8] Lt. Gov. Gandy, Judge Payne, Judge Denise S. Owens, Pat Bennett, Judith J. Johnson, Lynn Fitch Mitchell, Deanne M. Mosley, Jean Smith Vaughan, Jackie W. Rozier, and Carol C. West signed the petition.

[9] A copy of the petition is on file with the Administrative Office of Courts.

[10] For a copy of Supreme Court of Mississippi Order numbered 97-M-01581, August 26, 1998, see Appendix A.

Goals

The Court further enumerated the following three goals for the Task Force:

1. To determine whether the design, operation, laws, rules, practices and conduct of the judicial system result in inequality between men and women litigants, lawyers, judges, witnesses, court personnel and all those who come into contact with the judicial system.
2. To assess the real or perceived effects of gender bias on courtroom interaction and the judicial decision-making process.
3. To educate the bench, bar and public about gender fairness in the judicial system and to make appropriate recommendations to the Supreme Court.

Implementation Plan

The Court offered specific methodological and substantive guidance to the Task Force through the following implementation plan: study reports of task forces of other states; prepare and send surveys to members of the bar, judges, and court personnel; compile statistical information from the surveys; conduct public hearings statewide; review judicial decisions in substantive law areas; solicit written comments from interested persons and groups; cooperate with applicable bar committees and groups; analyze studies from government and private agencies; and, conduct meetings with regional bar organizations

Duration

The Court further stipulated that the Task Force would exist for a period of three years from its establishment, and upon the conclusion of its work would submit an official report to the Supreme Court, the Legislature, and the public. Its recommendations would include, but were not limited to, rule proposals, legislation, and educational programs. It should be noted that the Supreme Court in January 2001 extended the

term of the Task Force through June 30, 2003.[11]

Membership and Organization of the Task Force

The fifty people, thirty-seven women and thirteen men, who served on the Task Force represented the demographic diversity of Mississippi as the 1998 Order issued by the Supreme Court stipulated. The membership appointed by the Court included both lawyers and non-lawyers. Former, but not current, judges also served. The members of the Task Force volunteered their time and energy to this enterprise, including attendance at formal meetings as well as participation in other activities. Of note, they also paid their own expenses.

An Executive Committee, consisting of the Honorary Chair, two Co-Chairs, a Secretary, a Treasurer, two section Chairs, and two elected At-Large members, managed the operations of the task force. Former Lieutenant Governor Evelyn Gandy served as the Honorary Chair,[12] with Deanne Mosley, Esq., and Amy Whitten, Esq., as Co-Chairs. The remaining officers were Carol West, Esq. (Secretary), Susan Tsimortos, Esq. (Treasurer), Mark Chinn, Esq. (Chair of the Operations and Development Section), Constance Slaughter-Harvey, Esq. (Chair of the Issues Analysis and Development Section), and at-large members, State Representative Linda Coleman and Circuit Clerk Gayle Parker. The Executive Committee met at the discretion of the chairs to discuss pending matters (such as initial drafts of survey questionnaires) and to plan agendas for upcoming meetings. The Task Force adopted its own set of bylaws.[13]

The operating budgets of the Task Force have come from state funding and a development grant. For each of the past three fiscal years, the Mississippi Legislature has appropriated $26,500.00 to the Administrative Office of Courts (hereinafter "AOC") to facilitate the work of the Task Force. The State

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[11] *See,* Appendix B for a copy of Supreme Court of Mississippi Order numbered 89-R-99028, January 18, 2001.

[12] Former Chief Justice Lenore Prather initially asked Gov. Gandy to serve, and current Chief Justice Edwin Pittman requested that she continue in the post.

[13] *See*, Appendix C.

Justice Institute in 2000 provided a grant in the amount of $13,500.00 to cover expenses of consultants on the project. It should be noted that the AOC has provided substantial clerical and administrative support for the Task Force.

SECTION III. LIAISONS WITH STATE LEGAL ENTITIES

To promote gender fairness in the Mississippi legal system, the Task Force believed that bench and bar must form a partnership committed to that goal. A common mission and a willingness to participate actively in that mission are indispensable to its success. The Task Force, therefore, considered it vital to routinely inform legal entities of its work over the past four years. To that end, it prepared and delivered two interim reports, one in 2000 and another in 2001, to the Supreme Court, the Mississippi Legislature, and other interested parties.[14] The Task Force kept in close contact with the following groups whose cooperation in educating their constituencies is essential to the detection and elimination of gender bias in the legal system: bar associations, the Mississippi Judicial College, and law schools.

The Bar Associations

From its inception, the Task Force made it a priority to communicate its mission to attorneys, especially through The Mississippi Bar and The Magnolia Bar. Efforts included an article published in *The Mississippi Lawyer* as well as presentations to various groups of lawyers throughout the state. Furthermore, all lawyers licensed in Mississippi received copies of the cover letter describing the Task Force's investigation and the questionnaire requesting their participation in the study. The Task Force also kept in contact with the Board of Bar Commissioners of the Mississippi Bar.

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[14] Copies of these interim reports are on file with the AOC.

The Mississippi Judicial College

The Task Force recognized the important role that the Mississippi Judicial College plays in the education of legal professionals in the state. The Judicial College offers regular seminars to all trial and appellate judges, public defenders, court administrators, court clerks, and court reporters. Honorary Chair Evelyn Gandy appointed an *ad hoc* committee to discuss with Judicial College staff the inclusion of gender fairness issues at judicial conferences and special training programs.[15] Task Force member and University of Mississippi law professor Debbie Bell served as the principal liaison to the Judicial College.

Law Schools

The Task Force also understood the importance of legal education as a means to instruct prospective lawyers and judges. Throughout the past four years, the Task Force advised the University of Mississippi School of Law and the Mississippi College School of Law of its progress, and faculty members from both law schools served as members of the Task Force.

SECTION IV. THE STUDY PROCESS AND THE FINDINGS OF THE TASK FORCE

Surveys

The Supreme Court Order charged the Task Force to determine whether, and to what extent, gender unfairness existed in the Mississippi court system. As the first step in its investigation, the Task Force drew upon the experiences and reports of task forces in other states and federal circuits[16] to

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[15] Amy Whitten chaired the *ad hoc* committee. Patricia Bennett, Betty Daugherty, Deanne Mosley, Robert Oswald, Vangela Wade, and Debbie Bell served on the committee.

[16] The Task Force collected and read the final reports from jurisdictions that had conducted studies. The consultants also reviewed these reports.

help it understand and frame the issues of gender fairness and unfairness. For purposes of this study, the Task Force defined gender bias in the following way. Gender bias is multidimensional. It encompasses the stereotypes that society has assigned to the behavior of men and women as well as the misconceptions relating to the relative values of work of men and women. Unfairness based on gender may manifest itself in multiple forms in the legal system. It may appear in the language of statutes or in the judicial interpretations of those statutes. Gender may be intentional or unintentional, overt or subtle. It may be revealed in inequitable salary and benefits packages for those who work in the court system. In interactions between and among judges, attorneys, and court personnel, gender unfairness may surface as insensitive attitudes and disrespectful treatment.

The Task Force sought an economic and effective method to ascertain the statewide experiences and perceptions of those whose familiarity with that system afforded them special insight. While the Order issued by the Mississippi Supreme Court outlined multiple methods for data collection, the Task Force chose a written survey for jurors and three sets of legal professionals,[17] attorneys, judges, and court personnel. Also, the Task Force conducted a telephone survey for the general public, held statewide public hearings, and solicited written comments.

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[17] Women constitute a small but increasingly important percentage of the Mississippi bar and bench. As of October 9, 2002, records of The Mississippi Bar indicate that 6,222 active members reside in the state. Of that total, some twenty-two percent are women. Among members of the appellate and trial court (Chancery, Circuit, and County) bench, the ration is similar. Of the current 137 total judges for those courts, some eighteen percent are women. Theresa Robinson, Membership Services Division of The Mississippi Bar, and Susan Stewart, AOC, provided the information on attorneys and judges, respectively, on October 9, 2002. Appendix D contains additional distributions for judges and leadership positions in The Mississippi Bar, the Young Lawyers Division of The Mississippi Bar, and The Magnolia Bar.

Survey Design

The Task Force retained an outside entity, the Social Science Research Laboratory at the University of Mississippi,[18] to insure the confidentiality of responses and to manage the receipt and coding of questionnaires as well as the entry and analysis of data. Drawing on the experience of task forces in other states, the Executive Committee proceeded to identify broad areas of substantive concern: the legal environment, access to justice, domestic and family law, and criminal law. Following these suggestions, the consultants then prepared drafts that the Executive Committee and then the entire Task Force, in turn, reviewed and approved. Separate questionnaires were developed for attorneys, judges, court personnel, and the public.[19] Each set of survey instruments contained closed and open-ended questions asking respondents to record their perceptions of gender bias based on personal observation and experience. To insure currency, the surveys specified recollections from the past three years. To insure neutrality, parallel questions were added to specify opposite gender. Respondents were also asked to include basic demographic information.

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[18] The SSRL is a joint enterprise of the Office of Research and the Department of Political Science. It is a nonprofit, cost-recovery unit designed to complement the University's three-fold mission of teaching, research, and service across all fields in the social sciences, with a particular emphasis on survey research and program evaluation. The following SSRL research team participated in the collection and analysis of data as well as in the preparation of the report to the Task Force: Dr. John W. Winkle III, Director of the Project and Professor of Political Science; Dr. John M. Bruce, Associate Professor of Political Science; Dr. Robert D. Brown, Director of the SSRL and Associate Professor of Political Science; Dr. Charles S. Smith, Jr., Associate Professor of Political Science; and, Ms. Kristie A. Bost-Mott, Associate Director of the SSRL The SSRL is experienced in research on state legal processes. *See* Social Science Research Laboratory, "Public Attitudes about the Mississippi Judiciary: A Report to the Judicial Advisory Study Committee" (1995).

[19] The questionnaires varied in content and in length. For the text of each respective questionnaire, see Appendices E, F, G, and H.

Surveys of the Public

The Task Force satisfied the charge of collecting public comment through a telephone survey of a randomly-selected sample of 611 Mississippians, 18 years of age and older,[20] during late June and early July 2002. The ratio of women-to-men approximated 60-40, and, importantly, a majority of respondents (fifty-two percent of the sample) reported direct personal experiences with the legal system. Most had served jury duty, while others had been parties to a lawsuit, or victims of crimes or summoned to testify in court. The format for this section of the report parallels the findings and commentary for the surveys of legal professionals. In most instances, similar if not identical questions were asked.

General Findings

· **A substantial plurality of Mississippians believes that the gender unfairness in the court system is limited and isolated.** Furthermore, respondents believed that the bias cut both way, affecting both men and women. To be sure, there were differences. For example, significantly more respondents claimed "widespread and subtle" biases directed toward women as opposed to men. In the main, however, what stood out about these results was their remarkable parity: women and men seem predisposed to feel that where problems existed, they existed for both.

· **Strong majorities agree that on the whole the Mississippi court system treats men and women fairly**. Among

[20] The demographics of the sample show a 70- 30, white to black, racial ratio. Education levels in the sample show that high school graduates and those with some college training are slightly over-represented. However, fully 10% of respondents never graduated from high school and over 40% report annual household incomes under $40,000.00. Thus, the sample contains substantial representation from the less-privileged, a group that is routinely under-represented in telephone survey results. Had the sample been limited in some respect – say, to registered voters – sample/population inequities across race, income, and education would have been very substantial. The more-inclusive strategy of randomly selecting respondents 18-years-of-age and older greatly minimizes the under-representation of Mississippians of lower socio-economic status.

those who disagreed with this assessment, there was no clear pattern of gender-specific sensitivity: women were generally more likely to disagree with the statement and yet men were more inclined than women to strongly disagree. These findings suggested a general level of satisfaction.

· **An overwhelming majority of Mississippians see no distinction between men and women in their competence as lawyers and judges**. Some ninety-two percent saw no difference in quality for attorneys, while a similar ninety percent believed the same for judges. With this high degree of confidence in the Mississippi bench, it is not at all surprising that a substantial majority of citizens, men and women alike, favored election as the principal means of judicial selection in the state.

The Legal Environment

Citizens, whether they use the legal system or not, should expect equal access, personal dignity, and fair handedness.

· **A strong majority of Mississippians believe that men and women are able to obtain good legal representation in family matters**. Some eighty percent of respondents thought access to counsel did not depend upon considerations of gender.

· **A majority agree, with most of them in robust concurrence, that women who participate in the legal process (as lawyers, litigants, witnesses, or jurors) are more likely than men to receive unwanted remarks about their appearance**. This finding essentially replicated the one yielded by the survey of legal professionals.

· **A majority of citizens believe that jurors assign equal value to the testimony of an expert witness or an ordinary witness**. More subtle forms of bias may surface in the legal environment. An intriguing question is whether jurors, whose primary tasks are to find facts and render verdicts derived from them, place differential weights on testimonial evidence. Whose view matters more, men or women? Most Mississippians saw no distinction at all. Women, however, were less likely than men to reach that conclusion, suggesting instead that juries were more likely to respect the views of

men.

· **Most Mississippians have neither witnessed nor heard about incidents of gender bias in the court system, but, among those who have, the bias influenced the outcome of the case**. Roughly two-thirds of those surveyed reported no experience, personal or vicarious with gender bias in the judicial system. About one-third of them answered affirmatively, though, indicating that they acknowledged at least an occasional unfairness present in the legal system. Importantly, of this one-third almost ninety percent perceived that the biased behavior unfairly influenced the outcome of the case.

Domestic and Family Law

Citizens arguably may have a stronger view than attorneys and judges on matters of child custody and support awards.

· **Strong majorities believe that men and women receive unequal treatment in Mississippi courts when it comes to child custody and support awards, and they regard women as the beneficiaries**. Almost two-thirds of the respondents said that child custody outcomes were markedly unequal, with a similar sixty percent saying the same about support awards. Overwhelming percentages regarded women as the undisputed beneficiaries of child custody (almost ninety percent) and child support (seventy-eight percent) awards. On the latter, the gender divide proved greater with ninety percent of men, compared to seventy percent of women, in agreement.

Criminal Law and Process

As in the survey of legal professionals, the focus here is the behavior of officials within the criminal justice system. Do prosecutors treat criminal defendants differently? And for those found guilty of similar crimes, do judges mete out similar penalties?

· **A majority believe that district attorneys act in a neutral manner toward criminal defendants**. Interestingly, a solid thirty percent disagreed and there was virtually no dif-

ference in the levels of agreement and disagreement along gender lines.

· **Mississippians are divided on whether defendants receive similar punishments for similar crimes**. When it comes to sentencing, some thirty-seven percent believed that defendants were treated equally while an almost equal percentage (forty percent) disagreed. Men were slightly more inclined than women to disagree with the notion of evenhanded punishment.

· **Citizens believe for the most part that police, district attorneys, and judges take complaints of domestic abuse seriously and treat victims with sensitivity**. Domestic violence is an increasingly disturbing concern nationwide, and the legal process' response is of interest to both decision-makers and citizens alike. While the findings here indicated that the public generally agreed that actors in the criminal justice system act responsibly, there was a noticeable pattern of descending trust. Seventy percent of those surveyed believed that judges showed respect and sensitivity, compared to diminished percentages for prosecutors (sixty-six percent) and for police (fifty-eight percent). Women were much less sanguine than men especially when it comes to law enforcement and prosecution.

· **A majority of Mississippians believe that courts are biased in domestic violence cases**. Some sixty percent of the public believed that courts are unfair to men in domestic violence cases, while twenty-eight percent disagreed. The gender divide was once again evident with men more inclined than women to hold that view. In contrast, only about one-third of respondents believed that women were victims of bias, while more than one-half (fifty-six percent) disagreed with that assertion. Once again men were more likely than women to dispute a victim status for women. On the matter of the severity of punishment for familiar assaults, Mississippians generally agreed that offenders in date rape cases received lighter sentences, and there was little difference in the views of men and women.

Surveys of Legal Professionals

The Administrative Office of Courts (AOC) assisted the Task Force by sending out all three surveys to legal professionals over a period of ten months. Using lists obtained from The Mississippi Bar, the AOC in July 2000 sent out the first set of questionnaires to 6,632 licensed attorneys.[21] Some seven months later, separate and specially-tailored questionnaires went out to all 635 trial and appellate court judges.[22] Finally, in May and June 2001, the AOC sent 2,526 surveys to court personnel.[23] Follow-up reminders and mailings were used to boost response rates and thereby decrease the statistical margin of error.

The Social Science Research Laboratory received and processed the following numbers of usable responses for each survey: attorneys-1,045 (15.8 percent; judges-153 (24.1 percent); and, court personnel-638 (26.9 percent). Importantly, in each survey set the ratio of male and female respondents approximated the actual ratio of men to women within the particular category of Mississippi legal professionals. For attorneys who self-identified (and not all did), the results showed a 74-26 ratio of men (723) to women (251). For judges, the ratio was about 85-15 (121 men to 21 women). And, for court personnel, the ratio was 17-83 (111 men to 527 women). The notable predominance of female responses distinguished the court personnel data set from the other two. While women

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[21] Because of the relatively small numbers of legal professionals in the state, the Task Force preferred to survey all attorneys, judges, and court personnel rather than to use random samples.

[22] The Task Force sought to contact judges of all appellate (Supreme Court and Court of Appeals) and all trial courts of general (Circuit, Chancery, and County) and limited jurisdiction (Justice Court and Municipal Court).

[23] Included in this total are 215 municipal court clerks, 86 justice court clerks, 50 county court personnel, 164 circuit and chancery court clerks, numerous deputy clerks of court, 243 members of the trial court support staff (court administrators, court reporters, law clerks, and legal research assistants), and 126 appellate court clerks, staff attorneys, and law clerks. It should be noted that initially 2,415 surveys were sent. At the request of the Task Force, the AOC sent a supplemental mailing on June 30, 2001 to 111 staff personnel in the Mississippi Supreme Court and Mississippi Court of Appeals.

are under represented in the highest professional ranks of the legal profession in Mississippi, such is not the case in the trenches of court operations. One result is that these data speak for the largest percentage of female professionals in the Mississippi court system. In summary, because these three response patterns represent well their general populations, researchers may generalize with greater confidence. It should be noted that some respondents were mistrustful of, and even hostile toward, the surveys, or thought them misguided.

General Findings

As mentioned in the Executive Summary, the following three broad findings are paramount, and, importantly, are consistent with ones from studies on gender bias in other states:

· ***First*, in general, patterns of gender bias in the Mississippi court system exist, but are perceived to be relatively low and non-systemic.** Most respondents in the survey described the bias as limited and isolated. Unfair conduct and outcomes, they concluded, came from individuals, and not from laws, policies, or rules.

· ***Second*, a majority believes, overall, that there is a greater measure of unfairness toward women than men in the state court system.**[24] The answers to two questions, replicated uniformly across all three surveys, provided a measure of summary attitudes. These asked respondents to choose statements that best described their overall perceptions of gender fairness in the Mississippi court system. One question focused on the fair treatment of women, and its counterpart focused on fair treatment of men:

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[24] Based on commentary gleaned from written replies to open-ended questions in our surveys, the Task Force can point to the fact that Mississippians believe that negative experiences are, in some cases, based on more than gender alone, or, for that matter unrelated to gender. They may be compounded by, or due solely to, forces such as race, age, and poverty, among others. Task forces whose charges have extended beyond the issue of gender unfairness point to these intersectional forces in creating bias in the legal system.

(1) There is no unfairness toward women/men in Mississippi courts.
(2) Unfairness toward women/men exists, but only in a few areas and with certain individuals.
(3) Unfairness toward women/men is widespread, but subtle and hard to detect.
(4) Unfairness toward women/men is widespread and readily apparent.

Almost two-thirds (sixty-five percent) of Mississippi judges, lawyers, and court personnel believed that there is unfairness toward women in Mississippi courts. In contrast, forty-four percent of all respondents perceived any unfairness toward men.

· ***Third*, perceptions of fairness or unfairness differ significantly between men and women**. The gender divide proved especially instructive. Simply put, women in the surveys showed greater awareness of the core issues. They were much more likely than men to observe and report incidents of biased behavior. Often women in the legal process saw females as targets and males as beneficiaries of prejudicial behavior, by word and deed, because of their gender. However, in some instances males are seen as victims of prejudicial behavior. These observations held true across all three sets of respondents-judges, lawyers, and court personnel.

Findings by Substantive Concern

As mentioned above, the Task Force structured its survey around four broad areas of substantive concern: the legal environment, access to justice, domestic and family law, and criminal law. Highlighted here are the important findings for each.[25]

[25] The full report prepared by the Social Science Research Lab is available on file at the AOC.

The Legal Environment

Participants in the legal process should expect to be treated with dignity and respect. Anecdotal evidence abounds to show that this expectation has gone unmet. The more common forms of disrespectful behavior, such as inappropriate sexual comments and demeaning jokes, observers say, are all too frequent both inside and outside the courtroom. Overt or subtle, deliberate or unintentional, these behaviors offend people and put them on unnecessary guard. A similar battery of questions in all three surveys produced the following findings:

· **Numbers of women, whether attorneys or judges or court personnel, report incidents of patronizing comments or unwanted touches**. Consistent with other findings, the perception of, and experience with, gender-biased behavior varied according to the sex of the respondent. While disrespectful behavior may be less evident and less overt today than years ago, its vestiges nonetheless remain.

· **Fully one-third of women attorneys have received, witnessed, or heard about remarks disrespectful to women**. Evidence, both empirical and anecdotal, suggests that women in our society are still the victims of disrespect. Many lawyers reported that they have routinely and inappropriately been called names, such as "honey," "dear," "sugar," or "little lady," both inside and outside the courtroom.

· **The perpetrators span the professional spectrum, though respondents tend to single out male attorneys more often than male judges or court personnel.**

· **Almost one-half of female attorneys believe that they were treated in a less dignified or unequal manner, and that made a difference in their practice of law.** Some claimed that they were perceived by men as unfit to litigate. A few said that differential standards applied in the styles of presentation. They reported that men who were aggressive in the courtroom were dubbed as "fighters" while women were often labeled as "bitches." They believed, moreover, that male attorneys were treated with greater respect by male judges than their female counterparts.

· **Female judges are more likely to believe that male**

judges and attorneys give one another more respect. They were also more likely to believe that juries gave more weight to men, whether attorneys or expert witnesses.

· **One-fourth of court personnel report experience or second-hand familiarity with female employees receiving suggestive and demeaning remarks as well as unwanted comments about their appearance.** Of all legal professionals surveyed, court personnel by virtue of their jobs have regular and frequent interactions with litigants, attorneys, judges, and fellow employees. They enjoy a special and important vantage point to witness the daily operations of the legal process. Much like attorneys and judges, women who work in the offices of the court system reported discomfort at unsolicited remarks about their appearance or role. Some ten percent attributed that behavior to fellow court personnel while about eighteen percent identified male attorneys.

· **Gender fairness is seldom addressed in the courthouse workplace in any formal or systematic way**. It appears to be treated in a much more episodic, if not haphazard, fashion. On the positive side, however, court personnel regarded their bosses as approachable and perceived judges as willing to intervene when instances of unfairness occurred.

· **Disturbing differences exist between the work environment perceptions of women and men who staff the courts.** Women were four times as likely as men to believe that their job responsibilities had been improperly increased because of their gender—twice as likely to report that they were asked to perform duties that would not be asked of their male colleagues. Women were more than twice as likely as men to report that hiring decisions in their court were gender-based and four times more likely to perceive career advancement limitations owing only to gender.

· **Fully forty-six percent of female respondents in the court personnel survey reported that their salaries were negatively influenced by their gender**. This finding compared to a mere 8.5 percent of the male respondents.

Access to Justice

The adversary process operates on assumptions of equal access and treatment. When users of courts perceive that they do not have the same access or receive the same treatment as others, their faith in the court system diminishes.

· **On the whole attorneys believe that litigants, indigent defendants, prospective jurors, and attorneys have equal access to good legal representation regardless of gender considerations**. Female attorneys, however, were less likely to agree. Furthermore, sixty percent of them believed that their male counterparts were favored in fee awards in civil cases.

Domestic and Family Law

The Task Force decided to tap perceptions of attorneys and judges in two general areas of substantive law, domestic and criminal. The battery of family law questions focused on issues of custody and support awards as well as property distribution.

· **In child custody, spousal support, and property distribution matters, attorneys who observe unfairness report that it is directed against men**. Again gender divided respondents, but in a new way. This time, men were more likely to see men as victims.

Criminal Law and Process

The Task Force asked questions on the issues of domestic abuse and sexual violence in large measure because of their increasing and disturbing national visibility.

· **Almost two-thirds of all attorneys perceive a bias against men complainants at the trial level in matters of alleged domestic abuse**. About one-fourth believed the same about women who filed charges. Again gender appeared influential. Female attorneys were significantly more likely to find bias against women in domestic abuse complaints.

· **Police, district attorneys, and judges take domestic abuse allegations seriously and treat victims with sen-**

sitivity. Most attorneys, regardless of their sex, believed that legal professionals acted responsibly. Yet differences based on gender did surface. Female judges, for example, were significantly less likely to think that victims of domestic violence or sexual crimes receive sensitive treatment. And less than two-thirds of women judges believed that the bench understands the cycle of violence that often drives abuse.

Public Hearings

The Supreme Court charged the Task Force to seek the views of citizens statewide by conducting public hearings. To give Mississippians the opportunity to relate directly their experiences with, or perceptions of, gender bias in the legal process, the Task Force scheduled three public hearings during the spring of 2002, one in each of the Supreme Court districts. Sessions were held in the following locations:
March 21-Jackson (Central District)-Mississippi Bar Center;
April 4-Oxford (Northern District)-Holman Hall, University of Mississippi; April 30-Hattiesburg (Southern District)-Sherill Community Center. The Task Force convened the hearings in the early evenings (5:30 p.m.-7:00 p.m.) in order to maximize public participation.

The Task Force earnestly advertised these open forums and urged concerned interested audiences to attend. On February 28, 2002, the leadership sent letters of notification to the following legal groups: Mississippi Bar Officers and Commissioners, Women in Profession Committee of the Mississippi Bar, Bench-Bar Liaison Committee of the Mississippi Bar, Mississippi Women Lawyers Association, Commission on the Status of Women, Magnolia Bar, district attorneys, trial judges, and local bar associations. Two weeks later, Beverly Pettigrew Kraft, the Public Information Officer of the Supreme Court and a member of the Task Force, sent a separate mailing to other interested parties, such as victim assistance coordinators, the Public Defender Association, Legal Services offices, Mississippi Department of Corrections Victim Services, crime victim groups, advocacy groups, and community service providers.

To reach the public, the AOC sent a series of timely press

releases to print and broadcast media throughout the state. In its quarterly publication, *Mississippi Courts-The Newsletter of the Mississippi Judiciary*, the AOC also featured articles on the work of the Task Force and alerted readers to the scheduled public hearings. Notwithstanding these publicity efforts, attendance fell well short of expectations.

Members of the Task Force attended and led the sessions, and court reporters transcribed the proceedings.[26] Judge Robert Gibbs, Attorney Susan Tsimortos, and Judge Robert Oswald served as moderators for the hearings in Jackson, Oxford, and Hattiesburg, respectively. Despite sparse attendance, discussions were lively. Two citizens at the Jackson forum recounted their personal experiences with the Mississippi legal system. Frustrated by what they perceived as differential treatment, each of these women attributed these inequities to gender bias. In Hattiesburg and in Oxford, the conversations mainly took place between panelists and legal professionals in the audience.

Written Comments

The Supreme Court Order instructed the Task Force to seek written comments from interested persons and groups. To that end, the Task Force used brief questionnaires to solicit additional public commentary. These separate sets of surveys were distributed at the public hearings, made available online at the Supreme Court website.[27] The efforts produced rather disappointing results, however. Only seven citizens completed and submitted their surveys to the AOC. While the number of responses is too small for meaningful scientific analysis, it is useful to identify the range of issues raised by these respondents. Almost all came from people who used their personal experiences with the legal system as the bases for their comments. They complained about sentencing, judicial misconduct, and disparities in treatment in child custody cases for

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[26] Transcripts of these sessions are available at the AOC.

[27] The survey distributed at the public hearings and posted on the Court's website is attached in Appendix I.

both men and women. They suggested that the court system be more sensitive to issues of sexual orientation and that courts provide routine follow-ups in domestic cases. Also a juror survey[28] was developed and administered to selected juries in each Supreme Court district through the cooperation of circuit judges and court administrators. The final set of surveys, completed by jurors at the end of their cases, disclosed the fact that these citizens witnessed no bias in the trials before them.

Comparisons

The study conducted by the Mississippi Task Force on Gender Fairness in the Courts roughly paralleled those conducted elsewhere. To be sure, however, different task forces received distinct charges and sometimes even unique emphases for study. For the most part, the findings, as outlined above, were remarkably similar to, and consistent with, discoveries made by state and federal commissions nationwide. In common areas of interest, the differences were ones of degree, not kind. All task forces have reported the presence of bias in their jurisdictions. Almost without exception, that unfairness appears to be non-systemic, limited, and harmful to women, similar to findings in Mississippi. Most reports described that prejudice in terms of a multifaceted climate of condescension and indifference. For the most part they discovered repeated instances of personal disrespect, not dissimilar to what this Task Force found. Based on the testimonies of legal professionals and citizens alike, many jurisdictions situated that biased conduct in work environments outside the courtroom proper. The most serious, and some would say even rampant, manifestation of unfairness occurred in judicial support systems. Task forces in only twenty states, including Mississippi, have systematically included court personnel as part of their investigations. All, however, have reported disquieting findings. Several states, such as New York, Maryland, and Massachusetts, reported truly hostile working condi-

[28] A copy of the Juror Survey is contained in Appendix J.

tions for women, attorneys and court staff alike, but those appear to represent the exception rather than the rule.

Who or what is guilty of the gender-biased conduct that does occur? On the whole it appears to be people, not state statutes nor local policies. More often than not, the evidence gleaned by task forces points at men, and particularly attorneys. No doubt anyone is capable of such behavior, and studies have documented disrespectful and insensitive conduct by men and women, lawyers and judges and court staff. In several states, such as Idaho, Illinois, Michigan, Minnesota, New Mexico, New Jersey, Rhode Island, and Texas, task force concerns over the behavior of male attorneys, however, have led to recommendations for the promulgation of strict disciplinary rules designed to curb gender-biased conduct.

Importantly, task forces have found and underscored that perceptions divide along gender lines, and to a lesser extent along positional lines (judge versus attorney). They discovered, as this Task Force did, meaningful differences between women and men with respect to both individual experiences and overall impressions of bias. In its 1994 report, the Ninth Circuit Task Force called it the "two different worlds" phenomenon, and study commissions ever since have used that phrase and echoed that conclusion. Life experiences shape perceptions, and when it comes to the issue of unfairness in the legal system the dichotomy in life experiences between men and women, legal professionals and private citizens alike, is significant.

Task force reports are for the most part hopeful. Their optimism in large measure stems from the fact that they have thoroughly studied the matter of gender fairness, identified and documented the need for change, offered reasonable recommendations to courts or judicial councils, and maintained faith in the system and its people to respond accordingly. Importantly, in some of those jurisdictions that completed their inquiries years ago, positive change has taken place. Follow-up studies report that the general climate within each court system has improved over time as a result of education and conscientious effort. Those who become aware of the harm of gender bias become less tolerant of it.

SECTION V: RECOMMENDATIONS

The Task Force on Gender Fairness in the Courts respectfully submits to the Mississippi Supreme Court the following set of recommendations designed to reduce, if not eliminate, bias in the administration of justice in the Mississippi legal system.

RECOMMENDATION

To promote public awareness of the Supreme Court's commitment to gender fairness and Canon 3 of the Code of Judicial Conduct, the Court should adopt a specific policy statement declaring that gender bias is unacceptable conduct and encouraging judges not to tolerate such bias. Such a policy statement would be widely distributed to all judges and court personnel and posted conspicuously throughout judicial buildings.

RECOMMENDATION

To assist in compliance with the Supreme Court's recent amendment of Canon 3 of the Code of Judicial Conduct, the Court should adopt and publish a guide which gives specific direction on the appropriate use of gender neutral communications in courtrooms and support offices of the judiciary. Such a guide would be distributed to all judges and appropriate court personnel and would serve as an educational tool on the use of gender appropriate language in written and oral communications.

RECOMMENDATION

The Court should establish a Gender Fairness Implementation Committee to assist the Court in developing the policy and guide mentioned above.

RECOMMENDATION

The Mississippi Judicial College should intensify its efforts to incorporate components on gender fairness in training programs for all of its constituent groups. The Judicial College should also develop mechanisms to train all court personnel on gender fairness issues.

RECOMMENDATION

The Mississippi Bar and all other organized bar, legal, and professional associations should develop methods to in-

crease the sensitivity of their members to the issues of gender fairness and to promote efforts to insure fairness in salaries, benefits, and other employment benefits.

RECOMMENDATION

The Court should direct appropriate entities to investigate salaries of court personnel to determine where inequities based on gender exist and to make recommendations to resolve such inequities.

RECOMMENDATION

Law schools in Mississippi should include discussions of gender fairness, when appropriate, in classrooms and clinical training programs.

RECOMMENDATION

The Supreme Court should consider if study is needed in additional areas. Two issues brought to the attention of the Task Force from public input and from surveys of legal professionals are (1) whether racial bias exists in the judicial system; and (2) whether the lack of financial resources impedes access to justice for litigant in Mississippi. In addition the Court should continue its support of the Access to Justice Summit as it examines financial impediments to the judicial system.

SECTION VI: CONCLUSION

Incidents of blatant sex discrimination are less frequent in our society than in decades past; that conclusion seems to obtain for the legal process as well. Yet some forms of gender unfairness plainly persist. The Mississippi court system is no exception. Most Mississippians, legal professionals and the general public alike, agree that gender-biased behavior still continues in our legal process, even though it may now be limited in scope and perhaps even isolated. That view is not just a matter of unsubstantiated perception; to the contrary, it rests on the real experiences of people. Furthermore, the biased conduct, whether intended or not, is not harmless. On the whole, evidence shows that women, not men, are more often injured. In particular, an unmistakable unevenness exists in the level of respect owed and treatment received. The need to embrace those civilizing influences, as Chief Justice

Hughes called them, is clear.

The Task Force is unable to situate a clear-cut location for this biased behavior in Mississippi. It tends to occur both inside and outside the courtroom, and for that matter across courts. For most of the respondents in the surveys, and especially so for court personnel, the focus is on trial courts of general and limited jurisdiction. But no one court, no one place, stands out in stark relief as a convenient culprit. On the other hand, it is somewhat easier from the survey results to identify a group who more often engages in biased behavior. Respondents tend to tag male attorneys as more common offenders. Yet no one, it seems, is immune. Judges and court personnel also come under fire. What this means is that all locales and actors within the court system deserve some attention from policymakers.

Reform is possible. On the surface the solution is simple, perhaps deceptively so. Educate people, make them aware of what gender bias is, and they will arguably change their behavior. In point of fact, people can be taught to look beyond external markers, to break down the unfortunate, albeit often natural, tendency to stereotype, and to refrain from acting on those impulses. The Task Force hopes that its recommendations to the Supreme Court to encourage more intense educational efforts in our bench and bar will result in visible and constructive changes in attitudes and behavior.

While gender unfairness is less overt now and far more subtle, it is still harmful. The dissimilar treatment of people marginalizes the importance and limits the potential of participants in the court system. To reach shared goals, public expectations and court expectations must converge. After all, the common objective is a judicial system that is accessible, affordable, comprehensible, fair, responsive, efficient, and nondiscriminatory. To that end, the need to promote a greater awareness of gender unfairness in Mississippi courts is tantamount to its elimination. Fair access to justice for litigants and equal treatment for legal professionals demand no less.

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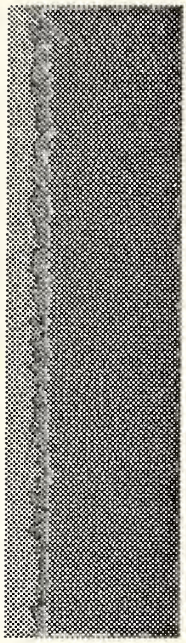

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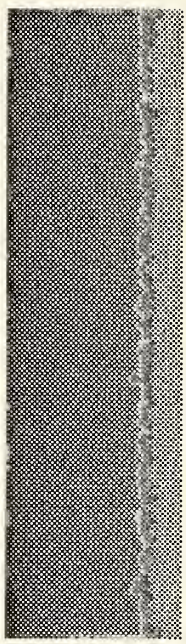

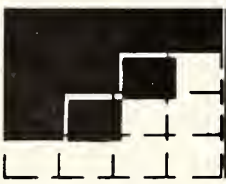

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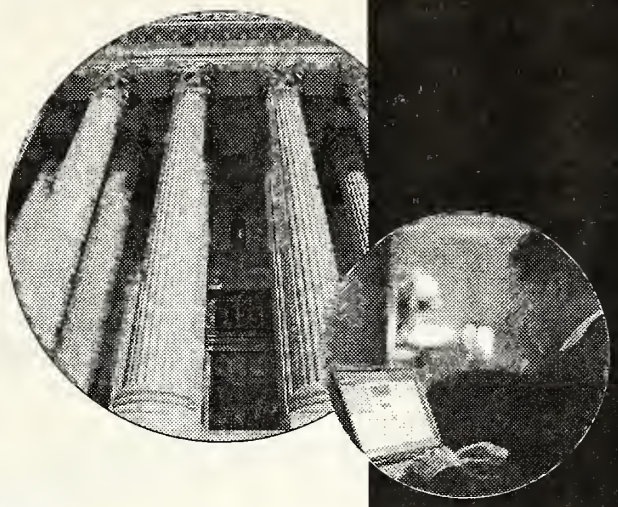

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